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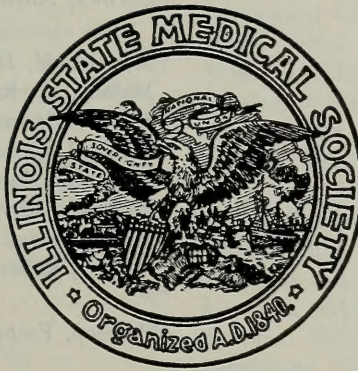
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# The Illinois Medical Journal

The Official Journal Of

The Illinois State Medical Society



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January — June, 1954

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SUBJECTIVE IMPROVEMENT	Patients with referable symptoms	Patients improved with Neodrol
Pain	28	22
Anorexia	11	10
General Malaise	10	8
Cough	7	6
Dyspnea	13	8
Headache	6	6
Nausea	6	4
Vomiting	4	3
<b>Total</b>	<b>36</b>	<b>31</b>

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*Escher, G. C., et al.: Clinical Research Proceedings 1:51 (Apr.) 1953.*

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# The ILLINOIS Medical Journal

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## Hernias and Hydroceles in Infants and Children

John L. Keeley, M.D.  
Chicago

Hernias and hydroceles can be considered together logically because of their common etiologic background. Both arise as abnormalities in the obliteration of the processus vaginalis and hernial sacs are found in a surprisingly high percentage of patients with hydroceles if a search is made for them. To perform an operation for one and completely overlook the other has, undoubtedly, occurred many times when the two have been routinely thought of as separate entities.

Hernias and hydroceles are, of course, more commonly found in male infants and children. The proportion of males varies from five to one to ten to one. Hydroceles in the female are of the canal of Nuck but, occasionally, they may be confused with incarcerated herniae. It has been said that direct hernias are practically unknown in these young patients. However, during the past year, we have encountered a hernia which, to all intents and purposes, was the exact counterpart of the direct hernia which is, occasionally, encountered in adults, that is, one in which there is a defect in the transversalis fascia instead of a thinning out and stretching of this layer.

The complete obliteration of the processus vaginalis is normally expected but the process on the right side closes later than on the left.

From the Departments of Surgery, Stritch School of Medicine of Loyola University, Mercy Hospital and Children's Division, Cook County Hospital.

Presented at the Annual Meeting, Illinois State Medical Society, Chicago, May 13, 1952.

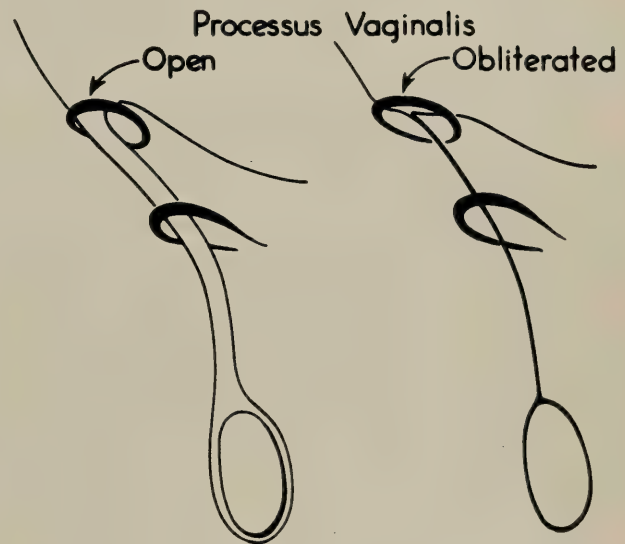


Figure 1

This is the explanation for the higher incidence of herniae on the right side (Figure 1). If the process is not obliterated completely, and permits a segmental collection of fluid in the midportion of the processus vaginalis (Figure 2A), a hydrocele of the cord results. This can be mistaken for a small or incomplete hernia because pressure will cause the mass to disappear through the external inguinal ring and into the inguinal canal (Figure 2B). Fluid, accumulating in the most distal portion of the processus vaginalis, results in the common type of hydrocele (Figure 2C).

A narrow communication between the processus vaginalis and the peritoneal cavity may persist (Figure 3A). It is not large enough to per-

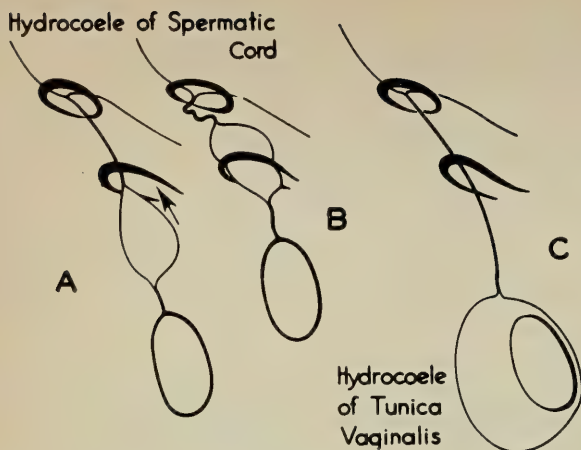


Figure 2

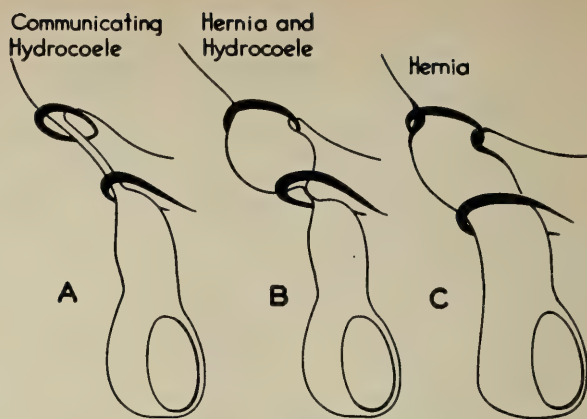


Figure 3

mit entrance of the small bowel but does permit peritoneal fluid to pass through slowly. The size of this opening determines the rate at which fluid passes through it. It may be so small that several hours in the upright position are necessary before a scrotal swelling appears. Although efforts, to reduce such a swelling promptly by external pressure, are unsuccessful, the swelling usually disappears after a night's rest in the recumbent position. If one has not had the opportunity of examining the swelling and detecting its true nature by its physical characteristics, and particularly by transillumination, a description of the abnormality, by an observant mother, will permit the diagnosis of communicating hydrocele to be made.

The contents of hernial sacs, in general, vary with age groups and small bowel is most commonly encountered in the hernias of infants and children in whom the omentum is not long enough to reach the inguinal region. There are exceptions, of course. Recently, we encountered a sliding hernia in a two-year-old child in which the cecum formed a portion of the wall just as it does in adult cases. There were the same technical considerations in the correction and repair of it. In female infants and children an ovary, and varying portions of the corresponding tube, may be found in the hernial sac or, as in a recent case of a sliding hernia, these structures formed a portion of the sac wall. In another case, encountered not long ago, the fundus of the uterus, as well as the ovary and tube, was present in the hernial sac. In another case, an irreducible and somewhat tender inguinal mass developed rapid-

ly in a female infant of three months. The lack of gastrointestinal disturbances suggested incarceration of an ovary and this situation was verified at operation.

The diagnosis of hernia in infants and children is perplexing at times. Frequently, we are forced to conclude that a hernia is present on the basis of the history alone as given by an intelligent mother who has observed a mass in the scrotum. In 50 per cent of the cases, the mother has been able to reduce the mass or it will subside spontaneously upon resumption of the recumbent position. If the mass does not disappear promptly when pressure is applied, and the mother states it is not present after a night's rest and does not return promptly on arising, a communicating hydrocele may be strongly suspected.

It is not always possible to examine these little patients when the hernia is out. In addition to the mother's history, it is helpful, especially in unilateral cases, to find thickening of the structures of the cord at the external ring due to the presence of the empty hernia sac and thickening of the cord structures and the various fascial layers covering them. However, in a well nourished baby, with a good layer of subcutaneous fat, thickening of the cord structures may be difficult to detect. Inversion of the scrotum, as practiced in adults, may supply additional evidence in the form of a protrusion through the external ring to support the diagnosis of a small hernia.

The detection of impulse at the hernial site is

not commonly useful in infants and children. If a definite thrust can be noted, as the baby cries, it may be a reliable finding. However, the sensation of definitely reducing something, when pressure is made over the site of the suspected hernia, has been more helpful in doubtful cases than the finding of an impulse brought about by a sudden increase in intra-abdominal pressure. If doubt exists, that a hernia is present, further observation and repeated examinations are indicated. Exploration, to determine the presence of a hernia, should be avoided; it often results in damage to the structures of the cord as the result of a determined search for a sac of some kind.

The indications for repair of hernias and hydroceles in infants and children have undergone considerable revision in recent years. Formerly, repair of a hernia in an infant resulted in atrophy of the corresponding testicle so frequently that the pediatricians preferred to use a truss until the child had reached his third, fourth or fifth year. It is a tribute to the improved technique of hernia repair in infants and children to know that now the pediatricians not only accept operation but also recommend it even in very young patients. This change in attitude is due to the current relative safety of modern anesthesia and the adoption of a more simple type of operation for hernia and hydroceles in infants and children. No longer is an adult hernia operation done to correct hernias in this age group.

In a young patient, an incarcerated hernia should be released, if possible, by elevation of the lower extremities using gravity to reduce the contents of the sac and influence the circulation and edema favorably. Appropriate sedation may be given. If reduction can thus be obtained, operative repair can be planned as an elective procedure. The time thus gained will permit complete subsidence of edema in the friable sac and make less difficult its separation from the surrounding structures prior to high ligation.

As an elective procedure we can say that, whenever the diagnosis of hernia is made, repair is indicated. The earlier the repair is done, the less chance there is of incarceration. The family doctor or pediatrician will not then have the responsibility of reducing incarcerations or wondering if each gastrointestinal upset is a manifestation of incarceration. It certainly solves the problem for anxious parents whose great concern

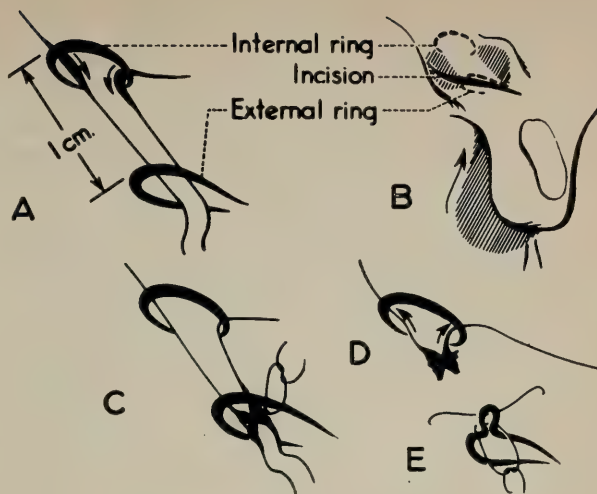


Figure 4

often makes normal care of an infant, especially the first or second child of young parents, a rather difficult problem. Recurrences in this age group are extremely rare. We have had one recurrence, we are aware of, and repaired it. The original hernia had been incarcerated and the degree of edema in the tissues made a normally simple operation difficult.

The combination of hernia and hydrocele (Figure 3 B) is not unusual and it is on this basis that the operation for either, or both, is done through an incision which is placed in a skin fold over the region of the external ring (Figure 4 B). A hydrocele sac can be delivered through this incision by separating the overlying layers above and exerting pressure on the scrotal contents from below. This incision also permits search for a possible hernia among the structures of the cord.

The essential features of a simple operation for the repair of infantile hernia are shown in Figure 4. The inguinal canal is short in infants and children (Fig 4 A). For that reason, the sac is isolated by picking it up through the separated fibers of the cremaster muscle in the region of the external ring. As soon as the sac is isolated, it is opened. Dissection, against a finger tip inside the sac, makes separation from the surrounding structures much safer. Once the sac is opened, it can be completely separated from the surrounding structures at this level and divided into a proximal portion which is followed to the region of the internal ring and a distal portion which is often intimately adherent to

the structures of the cord and the testicle. It is not necessary to remove the distal portion of the sac as the potential damage to the cord structures and resulting hematomas are far more serious than the remote possibility of a hydrocele developing in the remaining distal portion of the sac.

In a hernia, which has been present for some time, a little ring of scar tissue marks the level of the internal ring and is, probably due to traumatic aseptic peritonitis brought about by pressure from the edges of the internal ring. By traction on the upper portion of the sac, this thickened area can usually be delivered through the external ring (Figure 4 C). It is then possible to close off the sac at this scarred level by suture ligature. The redundant portion of the sac is excised and, when the suture is cut, it has been our experience that the stump of the sac retracts into the canal and comes to rest inside the internal ring (Figure 4 D). As in adult hernias, any maneuver, to suture the stump of the sac under the internal oblique muscle, simply tends to perpetuate the protusion of the peritoneal pouch through the internal ring

and, therefore, does not seem to be a logical component of any hernia operation. If the external ring is small or the inguinal canal is longer, as it will be in older children, the aponeurosis of the external oblique may be divided to provide adequate exposure in the region of the internal ring.

In an occasional case a stitch or two, to decrease the size of an enlarged external ring, may be used (Figure 4 E). The operation is completed by closing the subcutaneous tissue and skin after making certain the testicle is in its proper place. The fact that the incision has been made in a flexion crease, and that accurate closure of it is followed by early sealing off of the edges, makes a wound which is not likely to be contaminated in the postoperative period. Only a stamp-like dressing is used and is held in place with collodion or adhesive on a coating of tincture of benzoin. No attempt is made to restrict normal activities after recovery from the anesthetic in contrast to the restraints used in the past.

30 North Michigan Avenue

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## NEUROSIS FOLLOWING HEAD INJURY

Post-traumatic neurosis may follow an injury to any part of the body, but the great majority are related to head injuries. This is partly due to the special symbolic significance of the head, from the standpoint of the patient's unconscious mind, and is partly due to the concomitant occurrence of the post-concussion syndrome. The

latter, which is not a neurosis and which has an anatomico-physiologic basis related to the "com-motio cerebri," commonly comprises headaches, dizzy spells, and various disturbances in cerebral function. These must be distinguished from neurotic symptoms, but also their persistence may form a nucleus around which neurotic symptoms crystallize. *John D. Moriarty, M.D., Post-Traumatic Neuroses. Indust. Med. and Surg., August, 1953.*

# Do You Need to Know About Allergy?

**J. Harvey Black, M.D.**  
**Dallas, Texas**

Not long ago a friend said to me that he thought I had a nice occupation but that it must be lacking in interest since I would be seeing the same conditions day after day. Nothing could be further from the truth. In the early days of our work in allergy it was almost true for we saw largely asthma and hay fever. Today it may be seasonal conjunctivitis or mucous colitis; eczema or hydrarthrosis; asthma or an acute abdominal episode. There is as great a variety of conditions as may be seen in any field of medicine.

My title, then, is a rhetorical question and the answer, as I hope to convince you, is yes. Every one in the practice of medicine needs to know about allergy, not merely for the sake of being informed, but because, regardless of his field of practice, every one comes in contact with allergic conditions, in one form or another, and should be able to recognize them for what they are.

Allergy is a common condition. Less frequent, probably, than some enthusiastic practitioners would claim and more common than is realized by a considerable number of physicians. There may be many who disagree regarding the classification of some conditions as allergic but when the elimination of questioned conditions has been made by conservative men there still remains a hard core of approximately ten per cent of the population who suffer from one or another condition unquestionably allergic.

If this is true it is a condition frequent enough to justify our attention—more attention than it gets in many areas. I am convinced that one reason for the lack of attention to allergic conditions is that teaching in our medical schools has been neglectful of this phase of medicine. This comes about, not because of deliberate suppression, but because most of the teachers of medicine have, themselves, had little contact with allergic conditions and do not realize their

frequency nor their disabling character. Allergic conditions usually do not require hospitalization consequently those who have not engaged in private practice but whose work has been altogether in hospital wards, see few allergic conditions and do not realize that in private practice they are frequent and important. This means, too, that graduates in medicine enter private practice without adequate training in the recognition and care of these patients and are amazed to find that they are called frequently to care for them without preparation for it.

It probably is true that men have been deterred from the study of allergy by what they consider the unwarranted claims by some workers in the field. We admit that such claims have been made and offer apologies for them. But it is well to remember that this condition is a corollary of the development of any new field. Men who find explanation for some previously unexplainable conditions are quite likely to wonder if other unexplained conditions may be accounted for in the same way and, unless they are very careful in their thinking, are likely to be carried away by their enthusiasm and reach conclusions that are not warranted by sound, logical thinking. In the development of any new field this kind of thing though regrettable, may be expected. It should not be allowed to invalidate the tried and proven knowledge which has been discovered.

The mechanism of the allergic reaction is an antigen-antibody reaction resulting probably in the release of histamine. The tissue reaction consists of vascular dilation, increased capillary permeability with edema and cellular infiltration particularly of eosinophiles. If there are repeated reactions in the same site the condition may become irreversible with fibrosis, fibrinoid degeneration of collagen and, usually, numbers of eosinophiles. The reactions are the same everywhere. They may be modified by the tissue in which they develop and the location but basically they are the same.

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Presented before the General Assembly, 113th Annual Meeting, Illinois State Medical Society, Chicago, May 21, 1953.

Since the primary tissue reaction is a vascular change it would follow that allergic reaction can occur wherever there is vascular tissue which means that all physicians, regardless of their field of practice, will see allergic reactions and must consider them in the differential diagnoses of presumed organic diseases. Allergy can mimic many organic conditions and it sometimes requires careful investigation to determine whether the condition is organic or not. The primary and important requirement for recognition of allergic conditions is that they be kept within one's diagnostic horizon. If one will keep in mind that allergic conditions are common; that they may be found in any part of the body, and that they may closely mimic organic conditions, their recognition should not be too difficult.

I should like to cite some examples of conditions appearing in the various fields of practice which require consideration of allergy as the etiologic factor. The *ophthalmologist*, for example, sees patients suffering from conjunctivitis, keratitis or iritis which could be, and not infrequently are, due to sensitization. Proper treatment depends upon the correct diagnosis. The *rhinologist* must not only distinguish the seasonal hay fever but be able to differentiate recurring attacks of allergic rhinitis from recurring colds and he should remember that sometimes nasal blocking is due to a thyroid deficiency and not to an allergic reaction. The *otologist* should know that recurring attacks of otitis media may result from recurring attacks of allergic rhinitis and that, with the relief of the allergic conditions, the attacks of middle ear infection will not recur. He should remember, too, that recurring temporary deafness may be due to allergic edema as are many cases of Meniere's syndrome. Eczema of the ear is not always due to seborrhea or fungus or other infection; many of them are allergic in origin.

The *laryngologist* may be consulted because of continued or recurring hoarseness or a chronic, unproductive cough. These may result from the edema of an allergic reaction and require differentiation from organic conditions which might be serious. It is worth keeping in mind that people may have a severe cough with no other symptoms of consequence and that this may be entirely al-

lergic. Such a cough deserves careful investigation to determine if it may be due to laryngeal or bronchial disease.

The *internist* sees a great deal of allergy in one form or another. He sees asthma frequently and usually diagnoses it correctly without much difficulty. Occasionally he sees a patient with cardiac disease and also asthma and it is important to recognize the presence of both and to try to evaluate each. Emphysema is a frequent sequel of asthma but sometimes it appears unheralded by any previous disease. When it does, the diagnosis may be missed.

It is usually stated that the presence of a foreign body in the air passages—other than the nose—may be recognized by the abrupt onset of cough and dyspnea and frequently unilateral rales accompanied by fever and mucopurulent sputum. We had the opportunity of seeing a child in whom this question had to be decided and in whom the decision was very difficult. It is worth detailing here, I think, because a very competent chest specialist saw him first. It illustrates the fact that the diagnosis is not always easy and that the internist, the chest specialist or the pediatrician may be called upon to make the differentiation.

The patient was a 13 months old, male child whose mother stated that for the previous six months he had occasional attacks in which he would wheeze and become slightly dyspneic. These attacks were usually associated with colds and the attending pediatrician told the mother that the child had a mild asthma. This did not surprise her since she has a fourteen year old son who has been asthmatic through his childhood. Since the baby's attacks were mild and infrequent she did not concern herself particularly about them.

Two weeks before we saw him the maid picked him up to put him in his stroller and he very suddenly lost his voice. His mother ran to him, turned him upside down, struck him a few times and a small stone dropped from his mouth. At that time she found he was wheezing but she thinks he was wheezing slightly before this episode. She took him to a chest surgeon who went over his chest and made x-ray films. He found nothing but some asthmatic rales in the upper lobes and nothing in the lower chest. The films were entirely negative. There was no evidence

of a foreign body. For the two weeks prior to the time we saw him he continued to have some wheezing each night and sometimes during the day. Usually it was mild and did not seem to disturb him. He slept through the night without interruption. He had little cough and no fever. He had one attack which was severe enough for them to call the pediatrician who gave him an injection of epinephrine which gave the child no relief. He continued to have a little wheezing and cough.

The mother stated that the child had never appeared to care for milk and she thought it would be desirable to determine if he had developed an asthma due to some food so milk was removed from his diet and, since no improvement ensued, orange was taken away also. They then took him to Arizona where the elder brother had secured a large measure of relief. He was not improved noticeably there and any exertion brought on wheezing. After their return home he had a rather severe attack and he continued to wheeze almost constantly.

One month after we first saw him he was brought in and on examination coarse moist rales were found all through both lungs. There was some stridor as if there were some laryngeal obstruction. There were no fine sibilant rales heard. He had no fever. An injection of 0.2cc 1-1,000 epinephrine gave questionable help. Fluoroscopic examination did not reveal any foreign body nor evidence of obstruction in any one area. One fourth gram aminophyllin suppositories were advised to see if they would offer any relief.

Five days later he was brought in. The suppositories gave no relief. He was still wheezing and the mother stated that she thought he was definitely worse when he played on the floor. A small number of skin tests were done and a somewhat questionable reaction to house dust was obtained.

Five days later he was unimproved and, since his mother was trying to leave town for two weeks, we advised a bronchoscopic examination before she left. This was done the next day. A piece of chewed and hardened tinfoil about an inch in length was removed from his trachea and relief was almost immediate. The wheezing and coughing stopped and have not recurred.

This case is instructive because it illustrates

the difficulties in making a diagnosis when the question of asthma is so difficult to eliminate and when the foreign body is so hard to find except by bronchoscopic examination.

Loeffler's syndrome probably occurs more often than is recognized and needs to be kept in mind by the internist and the pediatrician.

A seven year old child, female, came under the care of a pediatrician who made a diagnosis of asthmatic bronchitis. The child had considerable dyspnea, a great deal of cough with very little mucopurulent sputum, and fever going as high as 102°. A chest film was made and an area of infiltration discovered in the right upper lobe in an area which had been clear in a film made a week before. It was believed that this was an area of atelectasis which had or would become infected so it was decided to do a lobectomy. The chest surgeon who was to do the operation was called out of town on the day before the proposed operation and it was postponed. Another film was made before the operation was postponed and, to the surprise of those concerned, it was found that the area of infiltration in the right upper lobe was no longer to be found but another was discovered in the other lung. The possibility of the transitory infiltrations being part of a Loeffler's syndrome then had to be considered and proved to be correct. But only a fortuitous circumstance saved the child from a lobectomy.

The *gastroenterologist*—and the internist—should know that gaseous distension is a frequent finding in allergic reactions, not only those in the gastrointestinal tract but even in asthma. And acute, colicky pain may occur in urticaria from swellings which develop in the gastrointestinal mucosa and that this pain may be relieved promptly by the use of epinephrine.

Occasionally one sees a patient with a rather well defined group of symptoms leading to the diagnosis of appendicitis or gall bladder disease and discovers that these symptoms may be elicited by the eating of some certain food and recurrences can be prevented by abstinence from that food. McIntosh, several years ago, and Dutton more recently have reported the finding of edema and large numbers of eosinophiles in appendices removed at operation and in which no other notable findings are present. The recurrence of symptoms after the removal of the

appendix or gallbladder, as occasionally happens, should lead one to suspect that the attacks may have been due to an allergic rather than an inflammatory reaction.

Recently we saw a twelve year old boy who had recurring attacks with pain in the abdomen, low grade fever, slight leucocytosis, some nausea and vomiting and some bleeding from the bowel. He was operated upon with a provisional diagnosis of appendicitis but no evidence of such involvement was found at operation and the appendix, which was removed, showed no inflammatory reaction. Attacks recurred after the operation but disappeared with the removal of some foods from his diet.

Asymptomatic bleeding from the bowel is occasionally seen and some of these, at least, are due to an allergic reaction sometimes to food, at others to drugs. We have seen a few children who had intestinal bleeding following use of aminophyllin and we have seen several who bled when they used certain foods. As an illustration of what can happen let me mention a woman who had an operation for carcinoma of the rectum. She had no symptoms for over a year and then began to bleed from the bowel. Her surgeon found no evidence of any recurrence at the operative site or elsewhere and, having no explanation for the bleeding, referred her for an allergic investigation. Following the removal of milk from her diet she has had no more bleeding though two years have passed since the examination.

It is quite probable that these conditions mentioned here are not very frequent but they probably occur oftener than is generally realized and keeping them in mind will increase one's diagnostic ability.

The *dermatologist* is quite aware of the fact that allergy is the explanation for many skin eruptions and the better versed he is in allergy the better work he does in dermatology.

The *orthopedist* occasionally finds arthritis on an allergic basis and occasionally sees intermittent hydrarthrosis due to sensitivity to food. Recognition of this fact makes differentiation easy.

The *neuropsychiatrist* is confronted with headaches and with syncope which may be on an allergic basis. I am convinced that allergic headaches constitute a minority of the headaches

seen but I am also convinced that those which are allergic can be satisfactorily relieved by recognition and proper treatment.

We have seen a very few cases of transient hemiplegia which were shown to be on an allergic basis. They occurred in young people with normal blood pressures; they came on without warning; the patients had other manifestations of allergy; the attacks cleared up within two or three days leaving no residue; they recurred after long and irregular intervals and disappeared with the removal of certain foods from the diet.

These conditions have been detailed, not to boast of our diagnostic ability nor to propose allergy as the explanation of all difficult diagnostic problems, but to remind you that allergic reactions occur quite generally and that every one should know something about them and keep them in mind in conditions which offer diagnostic difficulty. They may be common or rare but, sooner or later, every one finds them in his practice and they have to be dealt with. Sometimes the condition is urgent and requires prompt treatment so it would be well for the physician to know how to care for the immediate necessities. More important even is the need to recognize the condition so it may be dealt with properly.

There are some things that should be known by all of us regardless of our field of practice for at one time or another some of these facts will come up for consideration. For example, allergy is a disease beginning in early life. It may start when the child is a few weeks old or after several years but at least two thirds of our clinical allergies develop before the age of twenty. True asthma or hay fever may develop in elderly people but this is so uncommon that it is a good rule to remember that dyspnea developing after middle life, in one who has had no previous manifestations of allergy, is far more likely to be the result of cardiac disease than of asthma. Cardiac disease developing after the age of fifty is common while true asthma developing after that age is rare.

Parents frequently are told that they should not worry about their child's allergy since it will disappear as they grow older. Some times it does but far more often it does not. There are those who suffer from some sensitivity for awhile

and then, without obvious explanation, lose it. But the number of these is comparatively small; the far greater number continue to suffer until something is done about it. Although there are no definite figures available my own experience would lead me to believe that not more than ten or fifteen per cent recover spontaneously.

Mothers of asthmatic children who are thin and under weight frequently ask about the possibility of the development of tuberculosis in the asthmatic child. There have been various reports regarding the relationship between tuberculosis and the development of asthma or vice versa but the consensus seems to be that tuberculosis is certainly no more frequent in the asthmatic than in the non asthmatic population and the presence of asthma in a child does not appear to make him any more likely to contract tuberculosis.

People may become sensitive to a food which has been a frequent part of their diet for many years. Why, we do not know but we do know that after a long exposure to some food or contact substance, the patient may become sensitive to it. It is the patient not the food nor the environment which has changed. It also should be remembered that one does not become sensitive and develop symptoms from the first contact with the offending substance but that an incubation period is always required. This is readily demonstrated in drug allergy but it holds true for other forms of allergy as well.

Changes in weather, a cold, emotional disturbance or undue fatigue may, as nonspecific factors, precipitate attacks. Failure to recognize this fact has often led to the belief that climatic factors alone or emotional upsets may be the underlying cause of asthma or other allergic reactions. Recognition of this fact offers an explanation for why, on one occasion, the eating of some food, such as egg, may be followed by asthma while on another occasion the egg may be eaten without any asthma following. This may explain also why a patient, allergic to feathers, may sleep on a feather pillow every night but have asthma only at intervals. The explanation for this probably lies in the fact that most patients are only moderately or slightly sensitive to the antigen and, when other conditions are favorable, can tolerate the usual exposure without symptoms. Given the usual exposure and a

simultaneous change in the weather, a cold or an emotional upset and clinical symptoms are quite likely to follow. For this reason we can accept the weather changes, colds and emotional upsets as "accessory factors" but not the basic cause of the reaction. There is the occasional patient who is so sensitive that an exposure to the offending substance will produce an attack regardless of other conditions but these persons are few. These probably are the ones who are so sensitive that any real progress in hyposensitizing them is impossible.

It is quite common to have patients state that their attacks of asthma coincide with abrupt changes in the weather or that they are much more likely to have attacks in damp weather. The hay fever patient will state that he cannot have a fan blowing on him or sit beside an open window without having his symptoms aggravated and I have seen many bald headed men who slept with skull caps for a breeze blowing in on their bald heads would waken them with sneezing or nasal blocking. These people sneeze when they get out of bed or after a warm bath. They are quite sensitive to any chilling of the skin. This is simply the result of a vasomotor instability and is an exaggeration of a normal reaction. And, interestingly enough, these reactions all disappear when the allergic condition is controlled. A patient may state that he has asthma when the weather changes but if his allergic condition is controlled the weather may continue to change but he remains well. The same statements may be made about the influence of colds and emotional upsets.

There are two misconceptions for which allergists themselves are responsible. One is that patients become sensitive to a large number of substances. Multiple sensitivity is, of course, the rule. People who have had their allergic condition for years are quite likely to be sensitive to more than one thing. But people do not become allergic to great numbers of foods. I have had patients tell me that they reacted to so many things that the allergist told them there was nothing that could be done about it. And I have seen lists of substances amounting to as many as eighty items which were stated by the allergist to be responsible for the patient's condition. As a matter of fact, patients are usually sensitive to a comparatively few things and

proper attention to these produces satisfactory relief.

The other error for which allergists have to accept responsibility is that skin tests are infallible indicators of the patient's sensitivity. Of course, there are no infallible reactions in medicine and skin tests are no exception to the rule. They can be most helpful and can save a great deal of time in finding the offending substance but they must be only a part of the al-

lergist's armamentarium and must be accepted with discretion and made to correlate with the clinical history before they are pronounced the responsible agents.

The foregoing statements have been made to remind you that allergic conditions are very common; that they are found in all fields of medicine and are seen by every practitioner and that by keeping this in mind they may be discovered and given proper care.

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## The Use of an Iodide (Vioform) in Tuberculous Patients

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On the gastrointestinal service of a large tuberculosis sanitarium the problems peculiar to that disease must be differentiated from the usual variety of afflictions seen in everyday practice. Abdominal cramping, distention, excessive flatus with intermittent constipation and loose stools often are found to be due to amebic colitis. The problem of appropriate therapy in such individuals brings up the question of the advisability of using an iodine preparation such as Vioform (iodoxyquinoline), one of the least toxic amebicides. Since there is considerable difference of opinion on the potential harm in giving iodine in the presence of tuberculosis, 30 patients were watched over a three month period for any untoward effect vioform might have upon them.

*Materials and Methods:* The diagnosis of amebiasis was made upon finding the characteristic lesions with the proctoscope or through a positive stool examination.

Thirty patients with active pulmonary tuber-

culosis received 0.5 gm. Vioform daily for two (10 day) periods. Between these two courses 0.5 gm. Carbarsone was given for 10 days. All were under sanitarium care, at either complete or partial bed rest. Fourteen received streptomycin and six collapse therapy during part or all of the time they were under observation.

Twenty-six patients had far advanced\* and four had moderately advanced pulmonary tuberculosis. The patients with moderately advanced disease had negative sputum. Of those who were far advanced 10 had negative sputum for three months prior to Vioform therapy and 15 had positive sputum during this period. The sputum of one patient became negative during anti-amebic therapy.

None of the moderately advanced patients had extrapulmonary tuberculous complications. Of those with far advanced disease and negative sputum two had tuberculous empyema, one tuberculous enterocolitis, and one tuberculous peritonitis. The remainder with far advanced disease and positive sputum included five with tuberculous enterocolitis, one with tuberculous laryngitis, one with tuberculous empyema, and one with tuberculous enterocolitis and laryngitis.

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\*Classified moderately advanced and far advanced according to the standards of The National Tuberculosis Association.

These patients were observed closely for three months following Vioform administration. They were routinely checked with symptom inquiry, physical examination, weight and temperature records, x-ray studies, and sputum examinations.

*Results* (see Chart)

*A. Those with moderately advanced tuberculosis and negative sputum (four patients).*

All maintained negative sputum. None showed any change in the x-ray appearance of the pulmonary lesion. Physical examination and temperature also remained unchanged. No significant weight change occurred except in one patient who gained 22 pounds. One felt improved following therapy and three noted no change.

*B. Those with far advanced tuberculosis and negative sputum (10 patients).*

Nine of these patients maintained negative sputum and in one a positive sputum was found 44 days after completing her course of vioform. The chest x-ray remained unchanged in nine patients and in one there was some clearing. There was no weight change in nine and in one a 10 pound weight loss occurred during the three month observation period. Temperature and physical findings remained essentially the same in all patients. Three felt improved and seven noted no change.

*C. Those with far advanced tuberculosis and positive sputum (15 patients).*

Two patients converted to negative sputum during the course of vioform and one converted ten days after completing the course. One of these was receiving pneumoperitoneum and the other two were being treated with bed rest alone. The rest remained positive and there was no significant change in the number of bacilli found. By x-ray the lung lesions were improved in six patients, unchanged in four, and worse in five. Physical findings remained essentially the same in all patients. Six patients maintained their weight, four gained, two lost, and in three no record was made. No significant temperature change occurred in 12 and in three it was reduced. Ten patients felt improved following therapy especially in regard to their gastrointestinal symptoms; five noted no change.

*D. One patient with far advanced tuberculosis*

Tuberculous Status of Thirty Patients During Three Month Observation Period.

	Improved	Unchanged	Worse
Tuberculous Classification	0	30	0
Intestinal Symptoms	15	15	0
Physical Examination	0	30	0
Weight	6	20	4
Temperature	3	27	0
Chest X-ray	7	19	4
Sputum	4*	25	1**

\* Changed from positive to negative sputum.

\*\* Changed from negative to positive sputum.

*with a positive sputum before the first course of Vioform and a negative sputum before the second course.*

E.M., a 48 year old white female with far advanced tuberculosis was being treated with bed rest and right pneumothorax. Prior to her first course of Vioform she complained of fatigue and diarrhea. Her weight was 101 pounds and temperature was normal. X-ray revealed a right pneumothorax with collapse of the right upper lobe and infiltration in the left mid-lung field with cavitation. Sputum was positive on concentration. Proctoscopy revealed several fine, pin-head sized indentations scattered throughout the rectal ampulla which suggested an old amebic infection. She was given 0.5 gm. of Vioform daily for 20 days on the basis of the proctoscopic findings. Her sputum became negative while receiving the drug and remained negative from that time on. Bowel function became normal. Physical findings and chest x-ray remained unchanged. She gained nine pounds.

This case illustrates improvement of far advanced tuberculosis during a period in which Vioform was being administered. We do not wish to imply that iodine benefited the tuberculosis but merely that it did not hinder its improvement.

*E. Vioform therapy and extra-pulmonary tuberculous complications.*

Of the 30 patients studied, 12 had extra-pulmonary tuberculous complications; none of these was aggravated nor did any complications develop in the remaining 18.

*Case Report.*—M.K., a 41 year old colored female was admitted to the sanitarium in August, 1948 for far advanced tuberculosis with positive sputum and a six months pregnancy. She was treated with dihydrostreptomycin and delivered at term on November 27, 1948. Dihydrostreptomycin was continued and in January, 1949 the patient underwent a three-stage right thoracoplasty. Dihydrostreptomycin was discontinued in February, 1949 and in March her sputum became negative. In August, 1949 she began to deteriorate clinically and developed diarrhea with generalized cramping abdominal pain. Physical examination at that time revealed a right thoracoplasty with a few rales beneath it in the mid-lung field. Her weight was 121 pounds and her temperature was normal. X-ray was non-contributory; sputum still was negative. Proctoscopy revealed what appeared to be tuberculous ulcerations in the rectum; stool examination was negative. Because of the possibility of amebiasis she was given 0.5 gm. of vioform daily for 10 days. During the three following months no change in symptoms occurred except that she lost 11 pounds and ran a low grade fever to 99.8 degrees on occasion. Her sputum became positive 44 days after completing the vioform.

This case is presented in detail because it is the only one in which a patient with a negative sputum became positive and this, 44 days after treatment with the iodide. Such a change is not unexpected in a patient with far advanced progressive tuberculosis regardless of the type of therapy.

#### DISCUSSION

It is commonly taught and understood that iodine has an unfavorable effect in tuberculous patients. Yet various forms of iodine are commonly used in the disease without apparent harm. It is given in diagnostic procedures such as intravenous pyelograms, cholecystograms, and bronchograms. Informal discussions with those treating tuberculosis yield contradictory opinions as to the hazard from the use of iodine. Three popular text-books on pharmacology are unanimous in pointing out its dangers. One states<sup>1</sup> "In tuberculous patients, iodides arouse irritative reactions and may even activate a dormant lesion. In tuberculous patients, therefore, iodides are contraindicated." Another:<sup>2</sup> "Iodides tend to arouse irritative reactions to tuberculous lesions, similar to turberculin. This may sometimes be beneficial but it may convert dormant tuberculosis to active disease and untoward results have followed from the injection especially in radiography." A third:<sup>3</sup> "Iodides have to be used with care in cases of pulmonary phthisis, in which they often increase the cough and expec-

toration, and in some cases, it is alleged, cause hemoptysis and promote the infection of fresh tissue—many clinicians deprecate the use of iodide in all forms of tuberculosis."

In 1909 Sorel<sup>4</sup> reported that iodides hastened death somewhat in guinea pigs infected with tuberculosis. Since then considerable literature has accumulated and in an extensive review Sylla<sup>5</sup> was unable to arrive at any definite conclusion as to the safety or danger of the use of iodine in any form of tuberculosis. He reports iodine content of diseased tissues is higher than in the normal, whether the disease be tuberculous or carcinomatous. He doubts whether the iodine reaction is directly upon the bacilli.

Jobling<sup>6</sup> et al found that the unsaturated fatty acids of tubercle bacilli inhibit autolysis and the action of phagocytes to result in the formation of caseous material. If iodine were used to saturate the fatty acids the action of trypsin upon caseous material was enhanced. It would thus seem that iodine might favor resolution of tuberculous foci and phagocytosis. These observations might be the basis for the general good results Sylla reported in the use of iodine in all forms of human tuberculosis. Sylla concludes that benefit is accomplished through improvement in well being as a result of easier expectoration, freer breathing, often an increase in weight, reduction in fever, substantial reduction in the number of bacilli and improvement in the blood picture.

In experimental work with guinea pigs and rabbits, Smith<sup>7</sup> found that the influence of various iodine compounds on tuberculosis was negligible and some of the compounds seemed to be beneficial while others seemed harmful. More recently Featherstone<sup>8</sup> showed that "Tubercles formed in the omentum of the guinea pig as the result of the intraperitoneal injection of heat killed tubercle bacilli are not affected by large doses of inorganic iodine given over a period of 25 days."

The expectorant action of iodides in large doses (0.1 gm per kilo) has been demonstrated by Boyd<sup>9</sup> et al in cats and rabbits. The iodine content of the respiratory tract fluid was immediately increased from 25 to 50 per cent for as long as six hours after giving potassium iodide. The iodine content of this fluid reflected that of the blood. Inorganic iodide produced the highest blood levels with a peak of 24,000 micro-

grams falling to between 12,000 and 4,000 micrograms in 24 hours.

The normal range of protein bound blood iodine does not exceed 7.5 micrograms. However in a recent report Hyde and Hyde<sup>10</sup> found values of over 400 micrograms one week following instillation of lipiodol. The level dropped gradually to average approximately 200 micrograms one month after instillation. It required on the average, 17 months to attain normal values and some patients had elevated values for three or four years. It has been found by Curtis<sup>11</sup> et al that the blood iodine in tuberculous patients is essentially the same as in persons free of disease. Landy<sup>12</sup> gave lipiodol instillations to 32 patients with pulmonary tuberculosis. Nine had a slight rise in temperature, up to two degrees, 12 to 72 hours after the procedure. He states "the objection to iodine and iodides is more or less empirical and the idea that it does harm in tuberculosis has been entertained for ages. In reviewing the literature, however, one finds little to substantiate this opinion."

Knight and Miller<sup>13</sup> found the initial blood iodine level to be 23 micrograms in eight patients treated for amebiasis. They were given 0.75 gm of vioform daily for ten days and the highest concentration on the seventh day was 444 micrograms. Thus, rather high levels were obtained and although no determinations were made after ten days a similar amebicide (Diodoquin) which produced levels as high as 692 micrograms in one week was found to be only slightly lower at the end of three weeks. It would thus appear that rather high iodine levels were attained in our patients.

Entero-vioform was used by Althaus<sup>14</sup> in treating 11 patients with tuberculous cystitis. He noted some relief of pain and bladder spasm and in most cases there was less frequency and increased bladder capacity. The course of the tuberculosis was not influenced by the use of this drug.

Inorganic iodide is also capable of raising the blood iodine to high levels. Danowski<sup>15, 16</sup> et al used daily doses of 0.2 gm to 3 gm for as long as six months to get levels from 186 to 22,200 micrograms. The immediate rise was rapid but normal values returned in a few weeks after the iodide was discontinued.

## SUMMARY

Although no blood iodine studies were made upon our series of thirty patients we can assume that high values were obtained; these were high enough at least to attain a remission of symptoms due to amebiasis. Both organic and inorganic iodine are capable of giving rapid high blood levels which are promptly reflected in the respiratory fluid.

We were pleased to find no untoward symptoms in our patients over the three month observation period. Generally, these patients followed the usual course one might expect under good sanitarium care. Four patients converted from positive to negative sputum and only one became positive while under our observation. After reading the enthusiastic report of Sylla we had hoped that the tuberculous status of some might improve but such was not the case.

The intestinal symptoms of half these patients cleared completely; the rest established a normal bowel function except for occasional signs of irritability which could be cleared by diet adjustment. In all instances findings of active amebiasis were lacking after the completion of therapy.

## CONCLUSIONS

1. Thirty patients in various stages of active tuberculosis were treated for amebiasis with Vioform.
  2. Vioform therapy had no demonstrable effect upon pulmonary tuberculosis.
  3. Half of our patients were relieved of gastrointestinal symptoms.
  4. In reviewing the literature, the general opinion of those treating human tuberculosis seems to be that iodides can be used without harm.
- 30 N. Michigan Ave.

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# What Are We Getting Out of the Routine X-Ray Chest Examinations of Hospital Patients

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After x-rays were discovered by Roentgen, it was many years before even the most gross pathology of the internal organs could be portrayed satisfactorily. As knowledge of normal and abnormal findings increased and equipment was improved, the radiologist took his place in the ranks of those who were prepared to go to the aid of the sick.

For some years there has been a segment of the medical profession that saw beyond the healing of the immediately sick and endeavored to protect the well. Theirs has been a rather difficult and thankless task, since it is hard to persuade people to expend time and money in the pursuit and elimination of an unseen and unfelt foe, destructive as it may be when it strikes.

Yet some have had the courage to stand up against scourges, such as tuberculosis, and to win a great victory. I had the pleasure the other night of hearing Leigh Mitchell Hodges of Pennsylvania, sole survivor of the four found-

ers of the tuberculosis Christmas seal program in this country, recount the difficult times encountered in the launching of that great movement. In 1907 tuberculosis killed more men, women, and children than all of the wars, accidents, and other diseases put together. Now, only 46 years later, the death rate from tuberculosis in DuPage County, for example, is at the low figure of 5 per 100,000. But the battle is not won. Death rates are one thing and disease rates are another. We still have 800 cases on the follow-up roster in our county. Not all are active but all need supervision. At any time, just as soon as we relax our vigilance, tuberculosis can again march forth to become the White Plague.

Today we radiologists are of age. We are now joining the ranks of those who would detect a disease process before it makes its victim ill, thus increasing greatly the chance for recovery and eventually the elimination of the disease entirely. At present, our most significant contribution is in the field of tuberculosis control. Mass screening by x-ray films of the chest of apparently healthy persons has de-

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tected many cases of unsuspected and asymptomatic tuberculosis. I never fail to get a feeling of satisfaction upon making a diagnosis of early tuberculosis in an apparently healthy, asymptomatic person. When that person is an expectant or recently postpartum mother, one cannot help but feel that several persons have been snatched from the brink of disaster and given a chance for a normal life.

Satisfactory as is the discovery of active tuberculosis in an apparently healthy person, the procedure of routine chest x-ray examination must produce a sufficient yield of pathological material to justify the cost. I think we can do that with ease. At the Copley Hospital, in Aurora, Illinois, we x-rayed the chests of 3,476 persons, or about 25 per cent of the 13,385 admissions, from February 17, 1949 to October 8, 1951. During that time 45.9 per cent of the chests were considered entirely normal; 11.9 per cent showed signs of an ancient calcified tuberculous-like lesion; an additional 1.2 per cent showed hilum calcification, but no parenchymal focus could be identified; and 1.2 per cent showed evidence of adhesions involving the costophrenic sulci or pleural-pericardial surfaces. Pleural thickening of localized, generalized, or interlobar nature was seen in 0.3 per cent. The same percentage showed free pleural fluid of undetermined origin and the etiology is presumed to be tuberculosis, unless proved otherwise. Diffuse emphysema was seen in 0.9 per cent and localized emphysema in 0.14 per cent. Interstitial pulmonary fibrosis was seen in 0.6 per cent, mainly in the older age group. In 19 cases, or 0.5 per cent, clinically significant tuberculous-like parenchymal lesions were seen and in four of these, the changes were unsuspected by the clinician. The other cases had been seen previously at the local tuberculosis sanatorium. Since the end of statistical study, two moderately advanced cases of parenchymal tuberculosis, obviously active, were discovered.

To my mind the data just presented represents a significant yield of pathological findings, which would entirely justify the procedure of routine chest examination of the hospital patient. The moderate cost of \$2.00 charged for this examination would seem to represent a much better investment than many of the other routine

procedures which have been in vogue and unquestioned for many years.

The procedure of routine on-the-street x-ray-ing of the population has been accepted as economically sound. Yet the yield from general population surveying is less than 50 per cent of that which is obtained in the hospital population, as recently shown by Siegel, Plunkett, and Hilleboe. In addition, these men note that among those cases called probably active on the basis of routine chest examination in the hospital, there are more moderately and far advanced cases than in the on-the-street community surveys. Therefore, we are encountering a more dangerous case in the hospital survey.

Siegel, Plunkett and Hilleboe point out that the follow-up on the diagnosis of suspected tuberculosis made on the routine hospital admittance examination is not nearly so good as it should be. In a well planned and efficiently conducted survey in New York State, in 1947-1951, only 71.7 per cent of the cases suspected of having tuberculosis from the chest film had any follow-up examination. Of the group that did not have follow-up examination, only about one-half were initially diagnosed as probably inactive. Also, 27 per cent of the suspected active cases and 25 per cent of the probably active cases had not had follow-up examinations at the end of six months following x-ray examination. This was taken to indicate that satisfactory facilities for field supervision and follow-up cases are not yet uniformly available. The role of the general practitioner in this respect is extremely important. His awareness of the seriousness of the diagnosis and his ability to obtain further studies to rule out or confirm the diagnosis of tuberculosis would increase immeasurably the value of routine hospital chest x-ray examination.

In addition to the tuberculosis that was found, or suspected, on the routine chest films made at the Copley Memorial Hospital, many cardiovascular lesions were seen. Six cases, or 0.17 per cent were suspected of having congenital cardiac abnormalities. Mitral valvular disease was noted 22 times, or in 0.63 per cent. Three patients were thought to have aneurysms of the ventricular walls: 5.1 per cent showed enlargement of the left ventricle, sufficient to war-

rant comment; and 3.2 per cent showed lesions of the aorta, mainly diffuse dilation or sclerosis. Pulmonary vascular congestion was thought to be present in 0.5 per cent. The high proportion of immediate postpartum cases undoubtedly influenced this last figure.

It is a common experience in institutions which have routine chest x-ray examinations to have the diagnosis either made or indicated by the chest examination when it was not suspected at all clinically. Siegal, et al, note that almost one-half or the cases finally considered to represent active tuberculosis were not diagnosed as such while in the hospital.

Many asymptomatic, unsuspected pulmonary carcinomas have been detected as a result of routine hospital chest x-ray examinations. It is to be hoped that the incidence of successful surgical removal of these lesions will improve as the result of this program.

The yield of unsuspected lesions, tuberculous, cardiovascular, and neoplastic, and the aid in the evaluation of the complaints of the patient more than justify the effort and cost incident to routine x-ray examination of the chest of every hospital patient.

(1) Hilleboe, H. E., Siegal, William and Plunkett, Robert E.: Chest X-rays on Admission Pay Off Modern Hospital, July '51.

#### DISCUSSION

Dr. Theodore J. Wachowski, Aurora, Ill.: I think the questions asked are pertinent, and certainly show that we, in our preventive work, are in an embryonic stage of the investigation of the chests of healthy people. One of the reasons for my appearing on the program today was that only about 10 per cent of the

hospitals are doing that investigation at all, and I think it is quite an achievement when we can say that at Copley we have 25 per cent of admission x-rays.

Many difficulties arise, mainly on questions of technical help and expense to the patient. We are trying here to sell this program and point out that it is worthwhile. There are many defects. In x-raying postpartum women, we cannot get them all up after delivery, so that the problem there fundamentally is one of selling the general practitioner and the public on the value of this procedure and trying to get the general practitioner and the public to demand it.

I took part in a symposium for the Tuberculosis Institute of Cook County and the Chicago Tuberculosis Society about two months ago when we discussed the problem of why routine hospital admission chest x-rays are not used more. Dr. Marquardt, who represented the general practitioner, seemed to think highly of it. Mr. Ray Brown, of the University of Chicago Clinics, said it was not the hospital's fault; it was the radiologist's fault. Mr. Brown finally concluded, and I think logically, that the general practitioner has not awakened to the advantages of such a program, and he felt that until such a time the program could never be carried out 100 per cent, when it will be most effective. That is my best answer.

Dr. M. H. Seifert, Wilmette, Ill.: At our hospital it has been routine for a number of years for every patient who is to be delivered to be sent in after the first office visit to the obstetrician or general practitioner, and the chest film is included in the hospital fee.

Dr. Wachowski: At what predelivery date? It may be as many as seven or eight months before delivery. We have a routine of x-raying patients if they have not been x-rayed within six months.

Dr. Levine raised the point that every patient should be x-rayed every time he enters the hospital, even if he has been x-rayed only three months before. Just when are you going to do it? When are you going to stop getting more films?

# Recent Dermatologic Hazards in Industry

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Has there been an increase of industrial dermatoses due to new manufacturing process during the past few years? Systematic reading of industrial dermatologic literature and actual personal experience in industrial dermatoses show no significant increase of new industrial hazards. Perhaps the practical importance of all industrial diseases recently is responsible for an apparent increase of industrial hazards.

Many articles on industrial dermatoses in foreign and special journals are not read between the lines by physicians a little interested in industrial dermatology. An increase of queries in our medical journals on industrial dermatoses definitely indicate, however, a growing interest in this specialty within a specialty.

Some of the questions in our medical journals manifest a lack of understanding of the common industrial dermatoses. Occasionally the answers are written by a physician who has no special knowledge of the subject. For instance, a question from a physician in a recent medical journal concerns "a manufacturer of plastic articles with dermatitis among the employees. The personnel department believes that a phenol-formaldehyde resin in dust with which the employees come in contact is responsible. Is there a simple test to rule out new employees who will become sensitized to the dust?"

The answer by a physician is "that it is likely that the plastic involved in this industry will produce contact allergy; however, generally speaking, it will require long repeated contact before the person becomes sensitized. Hence, preemployment tests would be of little value, since virtually none of those destined to become sensitized will show reactions to this method."

A visit to the plant by the questioner would be more helpful than an answer from a physician who has not seen the actual work condition in a plastic plant. Apparently both physicians are

unaware of what is mentioned about phenol-formaldehyde resin in dermatologic textbooks. By proper application even the novice in industrial dermatology could learn about the simple and easily understood reactions which take place between industrial irritants and the skin.

In any large manufacturing center, such as Chicago, the industrial dermatoses are more frequent than all other industrial diseases. This occurrence is not casual, rather it is to be expected, since the skin is the largest organ of the body directly exposed to the many industrial irritants.

Of the industrial dermatoses, the most common one is industrial dermatitis since it constitutes 60 percent of this group. Approximately 80 percent of the cases of industrial dermatitis are due to primary irritants and 20 percent are due to sensitizers. Furthermore, in my industrial practice a complete examination of the skin shows industrial dermatitis limited to the hands and forearms in 65 percent of the cases. The diagnosis, in most cases, is reached by keeping in mind the "medical criteria" so essential in the just conclusion of industrial dermatitis. Common diagnostic errors in industrial dermatoses are created by physicians who are not familiar with "criteria for diagnosis" which were adopted by the Committee on Occupational Dermatoses of the American Medical Association.

Food handlers affected with dermatoses receive considerable attention because some of the patients are reported to health authorities as having infectious diseases. An article on this subject<sup>1</sup> several years ago does not include recent cutaneous irritants which are hazards, i. e.:

Hopkins<sup>2</sup> reported that the picking of mushrooms caused dermatitis in a man. The results of patch tests proved that mushrooms instead of insecticides was the cause of the eruption on his hands and eyelids.

A woman who, as a baker, was exposed to unusual amounts of cinnamon during the holiday period suffered from dermatitis on the hands,

<sup>1</sup> Presented before the Section on Dermatology, 113th Annual Meeting, Illinois State Medical Society, May 20, 1953.

wrists and forearms. Avoidance of cinnamon resulted in a prompt recovery. The history of exposure to unusual amounts of a sensitizer is often related to me by patients as the beginning of their trouble. An interesting medicolegal abstract<sup>3</sup> of a case dealing with permanent sensitivity due to cinnamon in a California court appeared in a recent issue of the J.A.M.A.

In fish canneries<sup>4</sup> in France, the gastric contents of mackerel caused dermatitis. Apparently the irritation was mild, since the use of protective creams prevented recurrences.

Contact dermatitis due to handling beef, pork and mutton<sup>5</sup> in the course of the handler's work is not too authentic, since repeat tests made when the skin cleared produced no reaction.

Some dermatoses connected with the fruit industry include lesions caused by lemon juice and by lemon oils<sup>6</sup> (terpenes). These substances are capable of producing ulcerations, rhagadiform lesions and diffuse erythemas.

Dermatoses of waiters and bakers are sometimes caused by citric acid and lemon oil.

Consumers of lemon juice and lemon essence may suffer from dermatoses through contact on ingestion. Some of the manifestations are cheilitis, hyperpigmentation, angioneurotic edema, aphthous ulcers, and papular or nodular eruptions.

In the castor oil<sup>7</sup> industry, during pressing and extracting castor oil from seeds and pulp, acute dermatitis develops.

Contact dermatitis due to sawdust derived from bamboo<sup>8</sup> occurred in a plant manufacturing rackets. This outbreak followed a new shipment of bamboo from Japan. One worker had handled bamboo for thirty years and two were new employees.

Carpenters handling lemon wood sawdust<sup>6</sup> are subject to contact dermatitis.

There are some miscellaneous causes of industrial dermatitis which are not too well known. A recent article on dermatoses due to brass is of unusual interest. Brass, an alloy of copper and zinc, with traces of other elements, is well known as a cause of metal fume fever. Morris warns that dermatologists should consider brass<sup>9</sup> as a cause of some of the usual dermatoses.

The pigment used in certain brands of wax crayons is para red. Has anyone seen contact dermatitis due to para red in wax crayons?

Para red in rotogravure ink received considerable attention as the cause of contact dermatitis several years ago.

A severe industrial dermatitis caused by phenothiazine<sup>10</sup> occurred on the hands and forearms of some of my patients. Two patients of Fleischhacker displayed a characteristic red coloring of the nails, and in one patient, discoloration of hair. Phenothiazine was used as a dye.

A rather unusual case of industrial dermatitis is attributed to the inhalation of chloromethylthiopene<sup>11</sup>. Experiments in a case of dermatitis caused by working with preparations of a synthetic antihistamine, chloromethylthiopene, showed that after disappearance of the primary disease, the same symptoms may reappear some time later, even on inhalation of the causative substance, as the result of an allergic mechanism, when predisposing conditions are created. Inhalants are alleged to be the cause of industrial dermatoses, but I have not been able to verify it so far.

Winston and Walsh called attention to chromate dermatitis<sup>12</sup> resulting from contact with diesel locomotive fluid as a hazard of growing importance in the railroad industry because of increasing use of diesel locomotives. A report of a case of chromate dermatitis resulting from contact with this fluid was mentioned.

A high percentage of the workers exposed to gas-oil<sup>13</sup> (diesel-oil) and lime water were affected by folliculitis and furuncles. The diesel oil was handled by workers in an asbestos-cement factory. In the railroad industry those handling diesel-oil affected with folliculitis, and it has been my experience that some railroad workers are careless in the wearing of oil-soaked clothes. They should be changed daily instead of once or twice a week.

Chrome ulcers<sup>14</sup> of the skin and nasal septum and their relation to patch testing was reported by Edmundson. Of 285 workers in a chrome arc-processing plant, 69.5% had chrome ulcers or scars, and 61.4% had perforated septa; there seemed to be a direct relationship between severity of exposure to chromate dusts and rate of attack upon the septum. Patch tests showed no evidence that chrome ulcers or perforated septa have a tendency to sensitize the individual to potassium dichromate.

In Illinois, chromate dermatitis has assumed considerable importance during the past year; however, in my practice the disease has not changed during the last thirty years.

Industrial dermatitis due to cement<sup>15</sup> with a chromate content has been reported in 33 to 94 percent of the patients.

Lamb and Lain report three cases of dermatitis apparently due to contact with dyes<sup>16</sup> used in the coloring of commercial gasoline. This was the first report of sensitization to dyes used for this purpose.

Between 1,000 and 1,500 different chemical entities go into the production of finished rubber<sup>17</sup>; therefore, the identification of specific allergens is difficult. For instance, in industry rubber gloves, rubber bands, rubber kneeling pads, rubber finger guards, rubber respirators, and rubber hand grips on vibrators are some sources of contact dermatitis. The tests of avoidance and re-exposure to the rubber should be tried. Elimination of rubber from direct contact with the skin is the only cure for contact dermatitis from this cause.

One manufacturer of rubber aprons has recently used monobenzyl ether of hydroquinone again. This chemical caused leukoderma a few years ago. Some cases have appeared again in my practice this last year. The chemist and manufacturer of the rubber aprons were reluctant to admit that they had repeated their error of a few years ago.

Workers with antibiotics<sup>18</sup> become sensitized too. It is noteworthy that Dalton found the workers in contact with penicillin were at their occupation longer before a reaction developed than were those handling streptomycin. Yet there were fewer sensitized to streptomycin than to penicillin. Likewise, employees who worked with chemical agents showed a great variability in the time elapsing between their initial contact with an offending agent and the onset of symptoms.

Adhesive tape dermatitis<sup>19</sup> is a common disease, particularly in industry. It has been difficult, at times, to convince some industrial surgeons of this hazard, and that sometimes it is the initial factor in causing irritation and infection of the skin. Peck and his coworkers have called attention to three types of adhesive tape irritation: (1) unimportant short reaction

due mainly to sticky adhesive mass; (2) sensitivity reaction; (3) reaction of irritation.

Schamberg<sup>20</sup> called attention to the many insults to which the skin of the lower limb amputation stump is subjected. When a prosthesis is worn, a variety of dermatoses localize in this area. It should be read by those who are interested in dermatological management of the cutaneous problems that may arise.

The use of a variety of ointments is still the practice in the treatment of burns. In my industrial practice many cases of therapeutic dermatitis still flow from this source. Whether or not the industrial physician and first aid departments have the courage to use the exposure treatment of burns remains to be seen during the next few years.

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#### DISCUSSION

Dr. Frederick J. Szymanski, Chicago: I wish to

compliment Doctor Weber on a very fine paper, and I can truthfully say that I enjoyed hearing it. I am sorry that I did not have an opportunity to read it before today's presentation. Therefore, my discussion will consist of a rapid review of the more important substances that have come to our attention recently as dermatologic hazards in industry. Doctor Weber has covered some of these points, but it does no harm to emphasize them.

The importance of occupational dermatitis cannot be stressed too strongly to practitioners of all types. A review of the reports of compensation boards of seven States shows that 65% of occupational diseases were dermatoses. The highest incidence of occupational dermatoses was seen in the industries of synthetic rubber manufacture and chemical and dye manufacture with 7.5% and 7% respectively. The lowest incidence of major industries was in automobile manufacture with 0.4%. Taking industry as a whole, excluding clerical workers, a conservative estimate of the number of workers affected by occupational diseases of the skin was 1% per year. In other words, one in every hundred workers suffered an occupational disorder of the skin each year.

Today, new agents causing disease of the skin are continually being recognized as new industries are developed, new raw materials are worked with, and new products produced. However, the types of reactions have remained the same, for the skin has relatively few ways to protest against irritation of its surface.

Prior to the advent of the Diesel type of locomotive, there was only an occasional case of occupational dermatitis among workers in railroad machine shops and roundhouses. Workers are now exposed to lubricating oils, fuel oils, radiator cooling fluid and solvents. Of these, the radiator cooling fluid has been the most troublesome. This fluid contains an anti-corrosion compound, Nalco No. 38, which is a mixture of chromates, dichromates, and strong alkalies, which are primary skin irritants in strong concentration and can produce sensitization even in dilute solutions on repeated exposures. Chronic chrome ulcers of hands, tongue oral mucosa and nasal septum have been recognized for many years and need no further comment at

this time. However, epidermal hypersensitivity as the result of industrial contact with chromates is of paramount importance to industrial physicians, dermatologists and general practitioners. Sensitivity develops after a comparatively long period of exposure. All patients with chromate dermatitis showed positive patch tests to samples of radiator fluid and to 0.25% sodium-bichromate solution. Unfortunately, this eruption responds rather slowly to therapy, and despite avoidance of the specific sensitizing substances, recovery is very slow and the dermatitis quite persistent. A 3% B. AL (dimercaprol) ointment has been recommended for local application in chromate dermatitis by some authors.

Hypersensitivity to chromates has been reported in 33-94% of patients with cement eczema. Only 5% of patients with other types of eczema and 5% of normal individuals have reacted positively to skin tests with chromates. Thus there seems to be a definite correlation between cement eczema and chromate allergy. Chemical analysis of various cements revealed chromium in minute quantities.

Beryllium workers and others exposed to beryllium compounds have both dermal lesions and respiratory symptoms. The most common manifestation in workers in the basic beryllium industry is an acute eczematous contact dermatitis. In the basic extraction plants, ulcers and granulomas over a knuckle and apparently resulting from implantation of a beryllium compound into the skin are not uncommon. The pathological picture in chronic beryllium granuloma and in pulmonary lesions of chronic berylliosis resemble sarcoidosis.

Although first reported in 1939, occupational leucoderma still warrants a few words of comment. The cause of the depigmentation is agerite alba, a trade name for monobenzyl ether of hydroquinone used as an anti-oxidant in rubber. Rubber gloves, finger cots, rubber aprons, rubber boots — all containing agerite alba have been incriminated in the production of leucoderma.

Finally, a case of allergic contact dermatitis has been reported due to pork corticotrophin. Therefore, this hormone must be considered among the occupational contact allergens of nurses, physicians and workers in pharmaceutical houses manufacturing it.

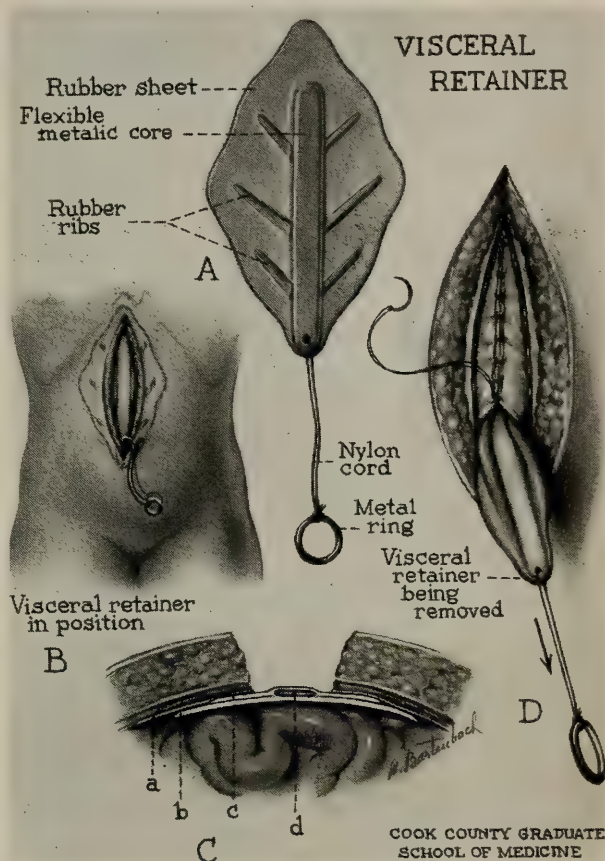
# A New Visceral Retainer

Raymond W. McNealy,\* M.D., and Jacob A. Glassman,\* M.D.,  
Chicago

The closure of an abdomen may sometimes be more difficult and time consuming than that part of the operation devoted to local pathology. The tendency of abdominal contents to protrude into the wound frequently requires considerable effort and dexterity on the part of an assistant in order to prevent accidental inclusion of the viscera in the suture. The practice of packing the viscera away with warm moist lap pads serves a useful purpose, but it is often a difficult problem to extract the lap pad when the final sutures are being inserted. The character of the moist gauze is such that its meshes have a tendency to scrape the viscera during its removal through the partly closed incision. Many instruments have been designed to facilitate the retention of viscera in the course of abdominal closure but most of them have had objectionable features which made them difficult to keep in place and even more difficult to extract after their function as a retentive agent had been served.

The instrument which we present here, is a modification of the one which Dr. McNealy designed in 1935. This new visceral retainer has been developed to meet more completely the needs of those who are doing abdominal surgery. The new features have been suggested by conditions which we have found during the course of our surgery and the use of the original visceral retainer. This new instrument will be made in three sizes, one approximately 15% smaller than the size of the original retainer and a second one, about 15% larger. There has been added reinforcing ribs which will give increased stability to the lateral wings without adding an appreciable amount to its bulk. These ribs serve also to prevent the retainer from slipping out of place once it is adjusted.

The general contour of the instrument was arrived at after careful observation of the retainer



when in place. The extra tongues at the apex and at the sides have been added to give additional anchorage and retentive power to the instrument. The ease with which the new visceral retainer can be folded into a narrow roll makes it very easy to remove when the wound is almost closed. Lubrication by the natural peritoneal fluids make it very slippery and prevent its scraping during its withdrawal.

The advantages of this new visceral retainer may be summarized as follows:

- 1.) It is easily sterilized and withstands repeated sterilization.
- 2.) It is readily inserted and easily withdrawn.
- 3.) It does not scrape or traumatize the peritoneal surfaces of the viscera.
- 4.) It effectively retains the omentum and viscera during straining periods which may occur during closure of the peritoneal cavity.

\*Professor of Surgery — Cook County Graduate School; President of Surgical Staff — Cook County Hospital, Chicago.

Attending Surgeon — Cook County Hospital, Chicago.

## MEDICAL JARGON

One expression that is particularly annoying to me is the use of the word "pathology" to signify abnormality or disease. All of us are guilty. The radiologist in his written report may say, "There is no pathology in the chest." The consultant may note, "I suspect pathology in the liver." Even the pathologist may say, "There is no demonstrable pathology." Pathology is one of the medical sciences and a field of specialty practice. It is the study of disease processes; it is not the disease process itself. And yet this usage of the word "pathology" is so ingrained I am sure nothing will change it.

Another common and related slip of the tongue or pen is the use of the term "serology" when a serologic test for syphilis is meant. We say "The serology is negative." Serology is the science dealing with composition and properties of blood serum; it is not the result of a specific test employing serologic techniques.

The word "malignancy" is commonly used in place of the more correct form, "malignant

tumor." "Malignancy" is a term which may be used to designate a harmful or threatening potentiality. Malignancy is characteristic of certain tumors, as it is of many other diseases, indicating their capacity to produce death. It is not the malignant tumor itself. The use of the terms "pathology," "serology," or "malignancy" in this erroneous manner cannot be justified by calling it a figure of speech. Common usage sometimes gives such forms a cloak of respectability. Webster's New International dictionary lists as one of the secondary meanings of pathology, "The morbid changes, collectively, arising in disease; the disease; the condition, as of an organ, tissue, or fluid, produced by disease." In spite of this recognition of misuse, I maintain that it is improper. It would be equally improper to say, after completing a pelvic examination in a female, "I can find no evidence of gynecology in this woman", or even, on a cloudy night, to say, "I can't see any astronomy out tonight." *Editorial, A. Crow To Pick. M. Ann. District of Columbia, June 1953.*

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## NO SPECIALTY BOARDS IN BRITAIN

We do not have in Britain what are called here, "specialty boards." Competence in the specialties is indicated by the possession of postgraduate diplomas awarded generally by the Royal Medical Colleges of which there are three in England, three in Scotland, and two in Ireland, and in some subjects by the Conjoint Board. Also, most of the universities have a degree of Master of Surgery. We use the term "physician" for what you call "internist." The oldest Royal College is the Royal College of Physicians. Hospitals making appointments as physicians accept as applicants only those who are members or fellows of the Royal College of Physicians. The examination for membership of the college is of very high standard and the percentage who pass it, generally below 20. About 30 members of the

college are selected every year at a meeting of the fellows and elected to the fellowship. The constitution of the Royal College of Obstetricians and Gynecologists is similar and candidates for hospital posts must have the diplomas of M.R.C.O.G. or F.R.C.O.G. With regard to surgery, the membership of this college is not a specialist qualification and the fellowship, which corresponds to membership of the other two colleges, is awarded after a stiff examination. The F.R.C.S. is a prerequisite for obtaining a post as a hospital surgeon. There are special diplomas in radiology, anesthesia, clinical pathology, child health, etc., but they do not have the standing of the M. R. C. P., M. R. C.O.G., or F. R. C. S. *Sir Allen Daley, M.D., The Relative Position of the Specialist, The General Practitioner, and the Public Health Officer in Britain. Maryland M.J., Jan. 1953.*

## CASE REPORTS



# Dermoid Cyst (Benign Teratoma) of the Testicle

**Robert L. Atkinson, M.D., F.A.C.S.**  
**Bloomington**

It is a well established fact that testicular tumors in all ages are rare occurrences. In children the incidence is much lower and, when one considers that at least 95% of testicular tumors are malignant, the occurrence of a benign tumor in a child would seem to warrant a report.

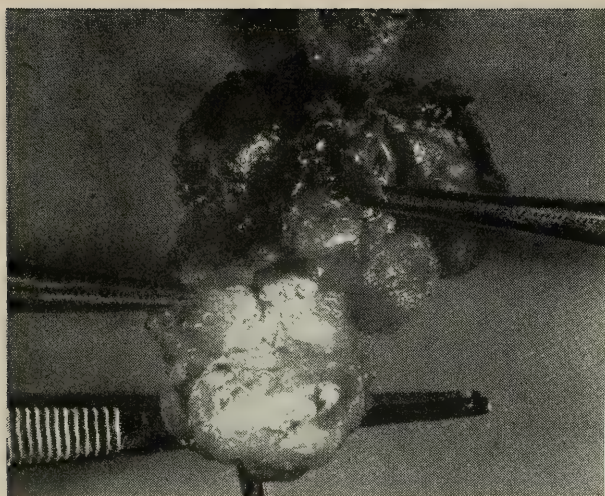
Recently two children have been operated upon and benign teratomata or dermoid cysts of the testicle removed.

Campbell states that "benign growths are clinical curiosities in children and include fibroma, interstitial cell tumors or hyperplasia, cysts and teratomatous structures such as lipoma, adenoma, chondroma, myoma, myxoma, and dermoids". In the literature the terms dermoid or dermoid cysts of the testicle seem to be used synonymously with the term benign teratoma. Dockerty et al reported 3 benign dermoid cysts of the testicle found at the Mayo Clinic between 1907 and 1942 inclusive. At the Clinic it was found that primary testicular tumors occur once in every 1,500 male admissions and of these

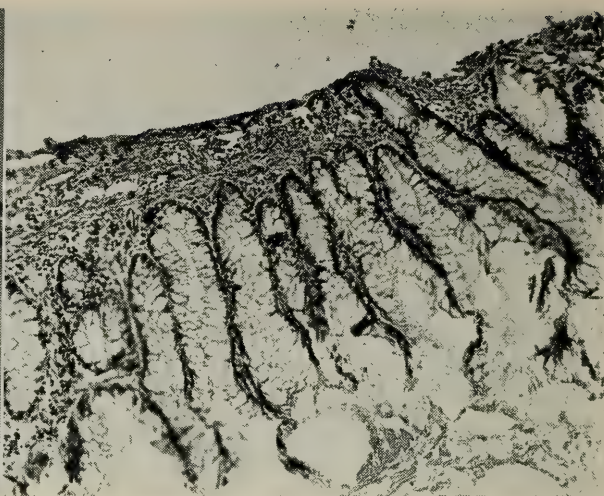
tumors only one out of 150 was a dermoid. Stevens found no record of dermoid cyst of the testicle in 171,933 consecutive admissions to the San Francisco County Hospital, although there were 7 malignant teratomata. He reported a dermoid cyst of the testicle in a 16 month old baby. Twinem encountered a case of a benign teratoma (dermoid) in a three year old boy and then reported that no case of this kind in a young boy had been found at the Brady Foundation for Urology at the New York Hospital from the time of its establishment, although a large number of testicular tumors had been treated.

In order not to confuse the issue, no attempt will be made to offer another classification of tumors of the testicle; it is sufficient to mention the fact that the two cases reported here are benign tumors occurring in the young.

*Case No. 1 (B.P.)* An 11 month old baby boy was referred for treatment of a hydrocele. The parents noticed that in the previous 6



**Figure 1.** Note the caseous material in the nodule held open by hemostats.



**Figure 2.** Intestinal structure of mucus producing columnar epithelial cells.

months, there had been a slow but progressive swelling in the left half of the scrotum which did not become smaller when the child was lying down for long periods of time. The patient appeared to be otherwise healthy. The left scrotum was enlarged to about 3 x 3 x 5 cm., was quite tense and transilluminated poorly. Palpation gave the impression of fluid confined under considerable tension. The child was admitted to the hospital with a working diagnosis of chronic acquired hydrocele.

The general physical examination revealed no abnormalities and the chest X-ray, urinalysis and admission blood counts were all normal.

Under inhalation anesthesia the left half of the scrotum was opened through a 5 cm. incision. Upon encountering the parietal layer of the tunica vaginalis, the expected normal landmarks were missing. A small amount of clear fluid was aspirated from the hydrocele and sent to the laboratory for culture (later reported sterile). The sac was incised and the interior was found to contain another rigid, sac-like structure, the walls of which were 3-4 mm. thick and had a rubbery consistency. On exploring the depths of this cystic mass with the tip of the little finger, a firm, rigid, calcareous ring of tissue was felt. Then from an unseen source some pale-yellow caseous material came into view, presumably from another compartment of the cyst. It was obvious that there was no testicle nor epididymus present and that the lesion was more than a simple hydrocele, consequently the cord was ligated high in the scrotum and the mass re-

moved. The wound was then closed and the patient removed to his room in excellent condition. Immediately after the operation, a urine specimen was collected and sent to the laboratory for an Ascheim-Zondek test which was subsequently reported as negative.

Pathological examination of the specimen revealed an irregular mass of red-brown tissue measuring 5 x 5 x 1.5 cm. presenting round, node-like structures measuring up to 2 cm. in diameter filled with thick, caseous material. (Figure 1).

Microscopically, the sections showed areas of skin formation and clear epithelial cells arranged in glandular formation resembling intestinal structures. (Figure 2).

*Case No. 2 (R.S.)* The mother of a 23 month old baby boy brought the child in for consultation concerning an acute swelling of the left half of the scrotum associated with tenderness and other signs of acute inflammation. It was learned that the child had seemed to strain to urinate at intervals during the preceding 2 months. This symptom was easily correlated with the finding of a very small urethral meatus and led to a diagnosis of acute epididymitis. After this acute infection had subsided, the child was hospitalized and a urethral meatotomy was done following which cystoscopy and bilateral retrograde pyelograms revealed a radiographically normal upper urinary tract and a normal bladder and urethra. The final diagnosis was healed epididymitis secondary to congenital urethral stenosis.

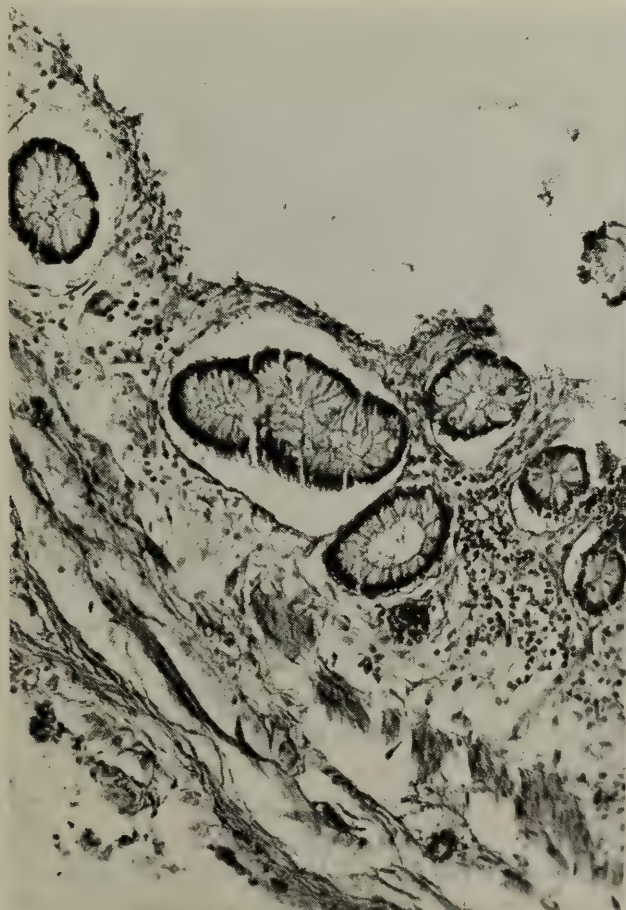
The child was discharged to the care of the family physician and not seen again until one year later when he was brought in by the parents who stated that there was a recurrent and intermittent swelling of the left half of the scrotum which, on one occasion, developed noticeably while the child was given a bath. Examination disclosed a 4 x 4 cm. transilluminable sac of fluid in the left scrotum associated with a firm, non-tender, crescentic mass measuring about 1 x 0.5 cm. situated just lateral to the hydrocele and thought to be the epididymus. Because of the persistence of the scrotal mass and the irreducibility of the hydrocele, surgical exploration was advised.

The child was hospitalized and a general physical examination, including a chest x-ray, blood chemistry determinations, and an Ascheim-Zondek assay of the urine revealed normal findings.

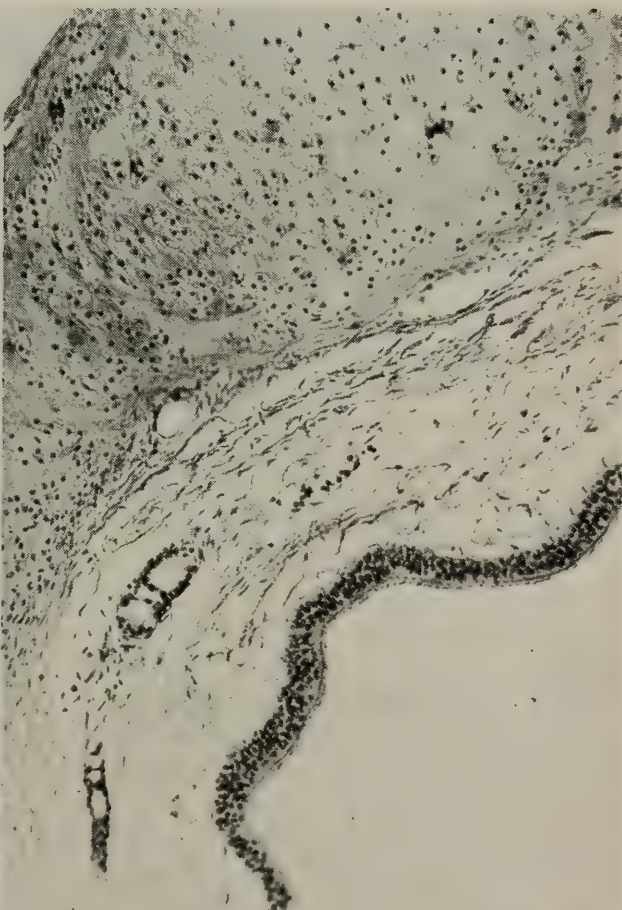
Under inhalation anesthesia, the left half of the scrotum was opened and the mass delivered

for better inspection, which disclosed that there was no hydrocele present but instead a cystic mass filled with mucoid, pale yellow fluid which was admixed with white, thick, purulent appearing material. No testicle nor epididymus could be identified, consequently the mass was exsized with apparently normal cord above it. The child recovered from the operation very rapidly and was discharged on the second post-operative day.

The gross specimen consisted of an irregular, partially encapsulated mass of tissue measuring 3.5 x 3.5 x 1 cm. The cut section revealed multilocular cysts filled with pale yellow caseous and mucoid material. The histological sections showed areas of secreting low columnar cells arranged in gland-like formation resembling intestinal epithelium (Figure 3) and areas of cartilage in apparent structural association with stratified epithelium (Figure 4). A high power view showed the epithelial cells of Figure 4 to be well supplied with cilia.



**Figure 3.** Islands of cells arranged in glandular form suggesting intestinal epithelium.



**Figure 4.** Large patch of cartilage apparently associated with stratified ciliated epithelium. This bears a striking resemblance to a cross section of a bronchus.

## DISCUSSION

It is probably coincidental that these two cases, unusual as they are, developed the lesions on the same (left) side. In case No. 1 the presence of the hydrocele suggests that either trauma or inflammation had preceded the formation of the tumor. In case No. 2 a positive history of acute inflammation of the scrotal contents antedated the appearance of the scrotal tumefaction by one year. These points are emphasized as possible etiological factors. Herbut mentions a case of a benign teratoma in a 25 year old man who injured his scrotum 13 years previous to the removal of the tumor. This patient was alive and well 20 years after removal of the teratoma which was histologically benign.

Assay of the urine for the presence of gonadotropic hormones should be done in all cases of testicular tumors, particularly the quantitative determination. Whereas the chorioepithelioma is the chief producer of the hormone (Prolan A of the anterior pituitary), other testicular tumors containing embryonal elements may also cause a positive Asheim-Zondek reaction. There

is a direct relationship of the number of mouse units of gonadotropic hormone present in the urine to the degree of neoplastic activity, thus, the titre offers a guide to the prognosis.

## SUMMARY

Two cases of benign teratoma or dermoid cyst of the testicle in children under two years of age are reported. The clinical, histological, and laboratory aspects of each case indicate no evidence of malignant tendency. Because of the benign nature of these lesions, no radiation therapy has been prescribed. Both children are in apparently good health and the prognosis should be excellent as regards life expectancy. 417 Griesheim Bldg.

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## THE SMALL MEDICAL LIBRARY

A medical library is not merely a depository for books, arranged in an orderly manner, under lock and key where they may collect dust and acquire the yellow discoloration of antiquity; it is a living organism which provides knowledge and sustenance to those who utilize its collection. Size is no index to the value of its books, nor does it reflect the value of the service given to

its patrons. A small medical library that is well organized and staffed by a trained medical librarian is one of the greatest factors in medical progress. It assists and furthers the education, reading and research of the professional staff, who in turn constantly raise the medical standards of the institution. *Editorial, The Hospital Medical Library. Medical Annals of the District of Columbia, Oct., 1953.*

# PATHOLOGY CONFERENCES

EDWIN F. HIRSCH, DEPARTMENT EDITOR



## Rupture of Cardiac Muscle with Recent Coronary Thrombosis:

- 1) Cardiac tamponade; 2) Interventricular septal perforation;
- 3) Ruptured papillary muscle of the mitral valve

**Edwin F. Hirsch, M.D.**

St. Luke's Hospital  
Chicago

### **1) CARDIAC INFARCT WITH RUPTURE INTO THE PERICARDIUM**

A white male aged 55 years walked into St. Luke's Hospital on October 1, 1945 after a sudden attack of severe precordial pain and faintness associated with marked diaphoresis, and died on October 6, 1945. He had been in good health and never had experienced a similar attack. When examined by Doctor George W. Scupham he was ashen, cyanotic, sweating profusely, had a blood pressure of 96/60 mm. Hg., and a pulse of 64 per minute. The heart tones were poor in quality. The erythrocytes were 5,000,000 and the leukocytes 13,450 per cu. mm. An electrocardiogram was interpreted as being consistent with an acute coronary occlusion. With oxygen and supportive therapy he remained in fair condition. On the fourth day he became

restless, irrational and was forcibly restrained. His blood pressure dropped to 84/60 mms. While tossing in bed he suddenly had a convulsion and died instantly.

The essentials of the anatomic diagnosis of the necropsy (complete) are:

Spontaneously perforated large recent infarct of the myocardium of the left ventricle and interventricular septum of the heart;

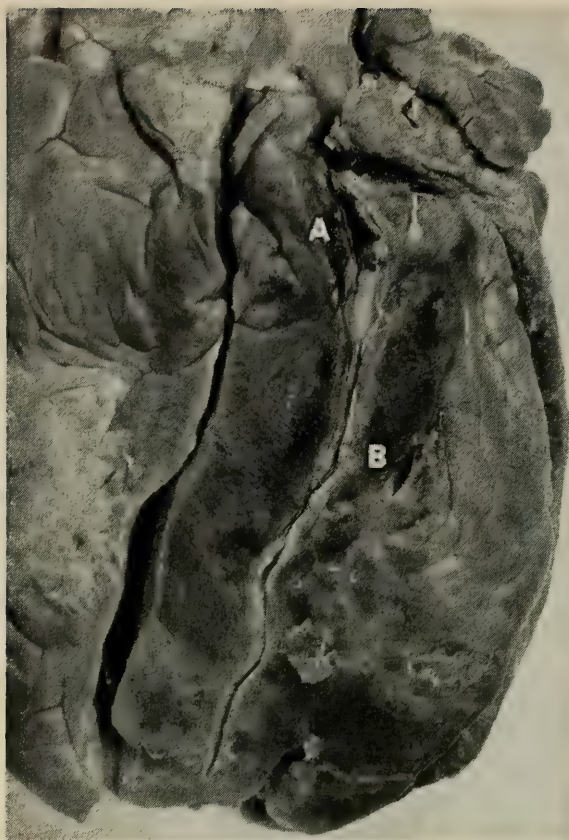
Huge hemopericardium;

Mural thrombosis of the anterior descending branch of the left coronary artery of the heart;

Marked ulcerated atherosclerosis of the coronary arteries and aorta;

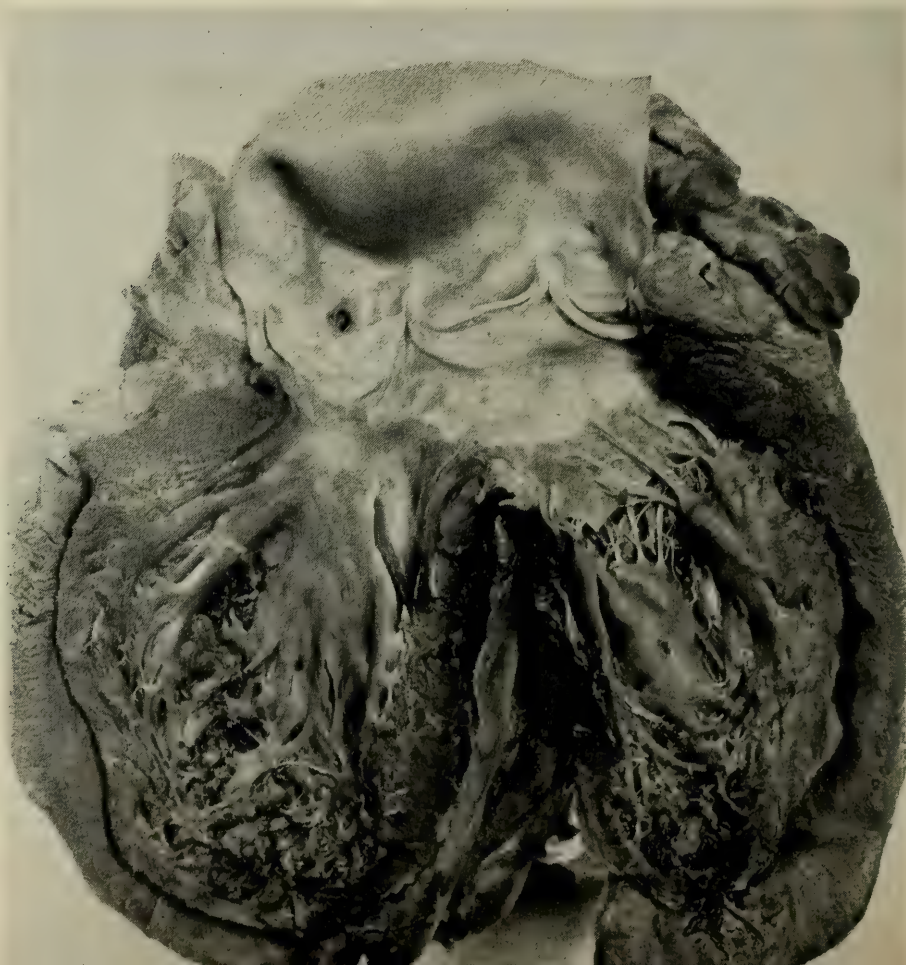
Etc.

The pericardial sac contained about 550 gms.



**Figure 1.** Photograph illustrating (A) thrombosis of the anterior descending branch of the left coronary artery and (B) the spontaneous perforation of the wall of the left ventricle. (Case 1)

of clotted and fluid blood. Near the center of the anterior surface of the left ventricle of the heart along the septum was a subepicardial hemorrhage and a vertical linear tear through the wall 1 cm. long (B Figure 1). The lining of the right side of the heart and the leaflets had no significant changes. The same was true of the left side except the ventricle. The chambers were dilated. In the lateral wall of the left ventricle near the septum in front was a recent infarct that extended from the apex to the base spreading into the lateral wall 3 cms. The muscle tissues here were yellow and friable. In the infarct 5 cms. below the aortic ring and 1 cm. to the left of the septum was a vertical tear through the wall of the left ventricle. On the endocardial side the tear was a slit 3 cms. long, partially covered by gray mural thrombi in a region 5 by 2 cms. (Figure 2). The epicardium around the tear was covered with fibrin. The infarct involved the anterior two-thirds of the septum from the apex to near the base. The lumen of the anterior descending branch of the left coronary artery near its origin was occluded by a dark red obturator thrombus that extended about 1.5 cms. (A Figure 1). The aorta had a marked ulcerated atherosclerosis.



**Figure 2.** Photograph illustrating mural thrombosis of the left ventricle of the heart.

## 2) CARDIAC INFARCT WITH RUPTURE OF THE INTERVENTRICULAR SEPTUM

A white male aged 77 years entered St. Luke's Hospital in the care of Doctor F. Ball on April 19, 1949 and died on April 21, 1949. He had been in good health until the day of admission when seated and reading in a public library he had become faint and toppled from his chair. When admitted to the hospital he was somewhat confused, had a small laceration of the tip of his nose and another of the scalp. His blood pressure was 180/100 mms. Hg. and he had some gastric distress. When examined later his blood pressure was 150/86 mms. Hg.; his temperature was 99°F. rectally; his pulse was 84 and his respirations were 20 per minute. The borders of the heart were not determined. There was no murmur and the rhythm was regular. His blood had 4,200,000 erythrocytes and 11,350 leukocytes per c.mm., the hemoglobin was 11.8 gms. percent. The non protein nitrogen of the blood was 44 and the sugar was 177 mgms per-

cent. The urine had no sugar or albumin. An electrocardiograph taken on the third day in the hospital disclosed no myocardial pathology. On the day following his admission to the hospital his blood pressure dropped from 140/80 to 92/10 mms Hg, his pulse increased from 80 to 104 and his respirations from 20 to 28 per minute. His only complaint was progressive weakness and gastric distress. Marked cardiac enlargement was now apparent, a loud and harsh murmur was heard at the apex, and a slight precordial thrill was felt. The leucocytes fluctuated between 10,600 and 17,400 per c.mm.; the blood pressure dropped to 80/60 mms. Hg; his pulse rate rose to 136 and his respirations to 36 per minute. He still insisted that he had no pain. Pulse and respiratory rates fell, he became cyanotic and died.

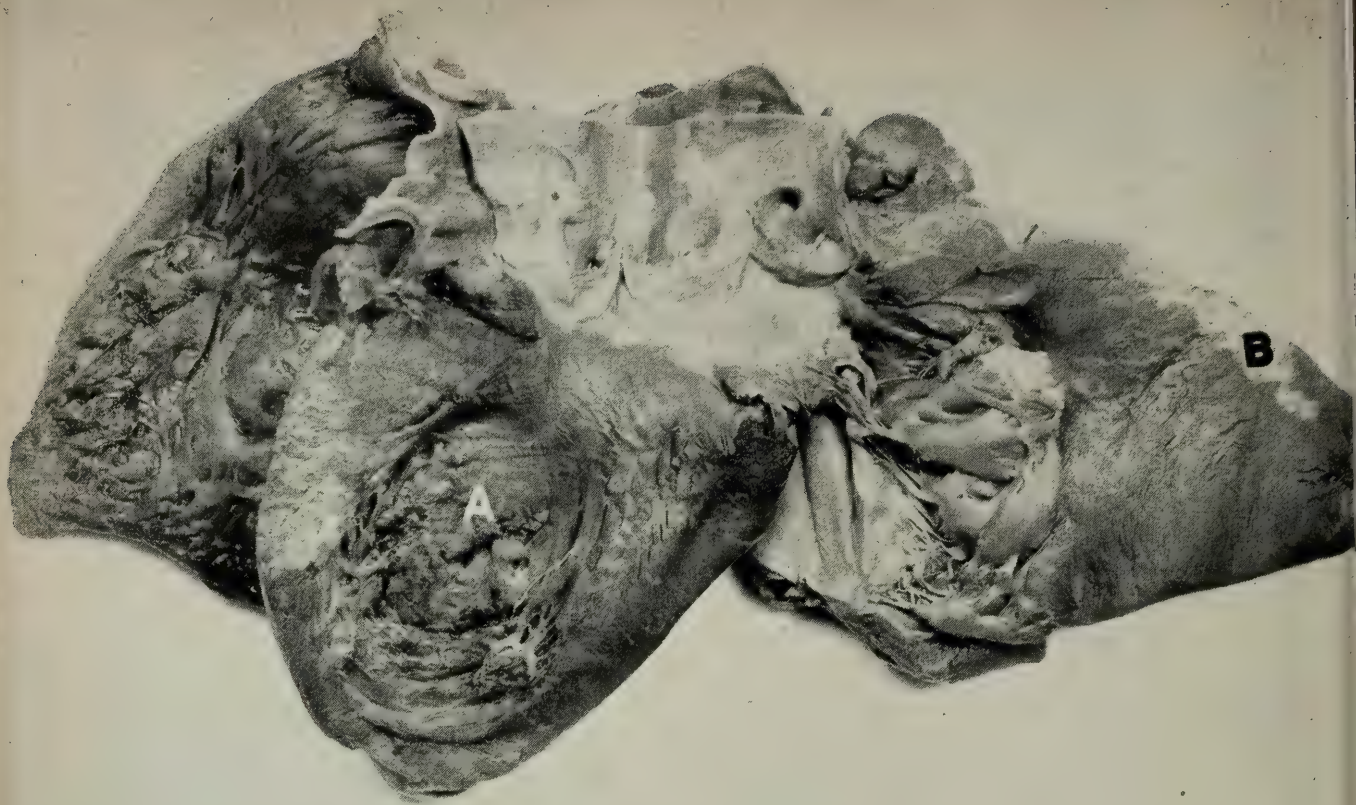
The essentials of the anatomic diagnosis (trunk) are:

Recent infarct with spontaneous perforation of the interventricular septum of the heart;



Figure 3. Photograph illustrating the interventricular perforation (A) viewed from the right side, and (B)

the old fibrous scar in the wall of the left ventricle of the heart. (Case 2)



**Figure 4. Photograph illustrating the interventricular perforation (A) viewed from the left side and (B)**

**the old fibrous scar in the wall of the left ventricle of the heart. (Case 2)**

Old fibrous scar of the lateral wall of the left ventricle of the heart;

Marked atherosclerosis of the coronary arteries and of the aorta and its main branches;

Senility;

Etc.

The lining of the pericardial sac and the epicardium were smooth. At the apex of the heart were a few subepicardial petechial hemorrhages. The lining of the right auricle, the right auricular appendage and of the right ventricle was smooth except that near the center of the septum was a hole with torn edges, 2 by 0.8 cms. and located midway between the base and the apex (A Figure 3). The edges of the perforation were gray and granular and around it were soft red-brown mural thrombi. The lining of the left auricle, of the left auricular appendage and of the left ventricle was smooth except that in the septum starting 2 cms. above the apex was a soft, rough gray-red region 3 cms. in dia. At the upper posterior edge of this was a perforation of the septum 1.5 by 1 cms. through which a probe passed into the right ventricle (A Figure 4). Surfaces made by cutting the

myocardium of the lateral wall of the left ventricle had a fibrous scar 6 by 1 cms. along the anterior edge (B Figures 3 and 4). The lining of the coronary arteries had marked fibrous and fatty changes but no definite occlusion of the lumen in the proximal portions. The heart weighed 440 grams. Histological preparations of the myocardium around the perforation of the septum had tissues with marked exudates of polynuclear leukocytes.

### **3) CARDIAC INFARCT WITH RUPTURE OF THE ANTERIOR PAPILLARY MUSCLE OF THE MITRAL VALVE**

An adult white woman aged 64 years was found dead in her apartment and her body was brought to St. Luke's Hospital for examination. She had returned to Chicago from a short trip two days before, and had made several telephone calls during this time including one to Doctor T. J. Coogan, her physician, asking for an office appointment but not mentioning any specific complaint.

The essentials of the anatomic diagnosis (complete necropsy) are:



**Figure 5.** Photograph illustrating (A) the stump of the ruptured papillary muscle of the anterior mitral leaflet and (B) the torn fragment attached to the chordae tendinae.

Large recent obturator thrombosis of the right coronary artery of the heart;  
Recent infarct of the septal myocardium and spontaneous rupture of the papillary muscle of the anterior mitral leaflet of the heart;  
Marked calcified atherosclerosis of the aorta and of its main branches;  
Chronic passive hyperemia of the liver and spleen;  
Slight bilateral hydrothorax, hydropericardium and ascites;  
Etc.

The heart weighed 340 gms. There were no significant changes of the valve structures and the lining of the heart chambers was smooth except of the left ventricle. The main papillary muscle of the anterior mitral leaflet was torn off 2 cms. from the base and the apex of this torn tissue was a granular gray surface covered with clotted blood, 1.5 by 1.5 cms. in dia. (A Figure 5). Attached to the anterior mitral leaflet by cordae tendinae was the torn off tip of this papillary muscle, 2.5 by 0.5 cms. and 5 to 8 mms. thick (B Figure 5). Surfaces made by cutting the lateral wall of the left ventricle had brown fibrillar muscle tissues but the septal myocar-

dium behind had a recent soft gray-yellow infarct 4.5 cms. long which extended to a depth of 1 to 3 cms. A thrombus occluded the lumen of the right coronary artery at a level 2.5 cms. from its origin. There was a marked calcified atherosclerosis of the aorta and its main branches. The changes in the viscera of the body otherwise were minor.

#### COMMENT

These three patients with fresh infarction of the heart muscle illustrate various complications that may occur in the necrotic myocardium. Rupture of the wall of the left ventricle with hemorrhage into the pericardial sac is the more common of the three complications described. The patient (case 2) with infarction of the septum and interventricular perforation had few of the cardinal symptoms of coronary thrombosis, such as precordial pain and a friction rub. However, the sudden development of a loud, harsh murmur at the apex and clinical signs of cardiac failure, suggested to his physician that the septum had ruptured. Rupture of a papillary muscle of the mitral valve is rare. The separation is usually near the tip. A few reports have described healing of the torn surface, life having continued sufficiently to permit this to occur.

## EDITORIALS



### A.M.A. CLINICAL SESSION IN ST. LOUIS

The Annual Clinical Session of the American Medical Association was held in St. Louis, December 1-4, 1953. On Monday, November 30, the Sixth Medical Public Relations Conference was held. At the morning session the basic subject was "Making a Public Relations Program Work", and following four presentations there was a "We'd Like to Know" question and answer period which was quite popular.

For the afternoon session the basic subjects were, "Selling Our Economic System", "How Others Do It", and "Mending Our Public Relations Fences". Each year at the A. M. A. meetings the "P. R." sessions have been of unusual interest and invariably draws a large attendance.

The Exhibits and Scientific Sessions were held in the large Kiel Auditorium for the four days of this Clinical Session. As usual, there were a considerable number of Illinois physicians appearing on the programs and also displaying interesting scientific exhibits.

The registration of physicians for the meeting was approximately 2,800, and the overall registration about 8,000. Illinois was indeed well represented with an unusually large number of Illinois members from the southern half of this state.

The meetings of the House of Delegates were held in the Jefferson Hotel. Illinois had ten

official delegates, and three members of the Illinois State Medical Society were delegates from their respective sections. All Illinois delegates were on hand for the session. At the first meeting of the House, it was reported by the Chairman of the A. M. A. Board of Trustees that an eighty year old doctor from Kentucky had been selected as the "General Practitioner of the Year" — Dr. Joseph I. Greenwell of New Haven, Kentucky. Doctor Greenwell had practiced for 53 years in Kentucky, his location being less than 20 miles from the birthplace of Abraham Lincoln.

As usual at the meetings of the House of Delegates, many resolutions were introduced, referred to reference committees, then acted upon when the reference committee reports were presented to the House. The transactions of the House of Delegates will be published in the Journal of the American Medical Association, and it is hoped that every member of the Illinois State Medical Society will read these interesting reports.

Even though there are many meetings held in all parts of this nation regularly, the most important of these we believe are those of the American Medical Association, and it is hoped that more Illinois physicians will attend these meetings, giving them a number one priority on the long list of meetings.

## **POSTGRADUATE CONFERENCES — 1953**

The Postgraduate Education Committee, through the autumn of 1953, presented six large and three small postgraduate conferences, with a total attendance of more than 600. Eight more large and six more small conferences are scheduled for the coming spring.

Large conferences have been staged in Sterling, Jacksonville, Kankakee, Cairo, Benton and Taylorville. Small ones have been held in Du Quoin, Eldorado and Fairfield. The medical schools of Northwestern and Loyola Universities and the University of Chicago, Passavant Hospital, Michael Reese Hospital and the Veterans' Administration Hospital have co-operated.

Most of the programs have been of the panel type, and all have proven highly popular.

The Kankakee program presented an unusual and welcome feature, when The Armour Laboratories of Chicago invited all attending physicians and their wives to visit the new Armour Pharmaceutical Center on U.S. Route 54, two miles north of Kankakee. Nearly 125 physicians accepted the invitation. They enjoyed luncheon and a guided tour of the huge new \$12,000,000 plant, then went to the Kankakee Hotel for the meeting and dinner.

They were greeted by Armour executives, including Robert E. Pearsall, executive vice-president, Edgar L. Patch, general manager of the Laboratories, and members of the medical staff, as well as by officers of the Illinois State Medical Society and the Kankakee County Medical Society. Willis I. Lewis, M.D., of Herrin, and Harold M. Camp, M.D., of Monmouth, president and secretary of the Illinois State Medical Society, and Edwin S. Hamilton, M.D., of Kankakee, trustee of the American Medical Society, were among the guests.

The Armour plant is Kankakee's newest and largest industrial acquisition. It employs some 600 people in the manufacture of various specialty drugs of animal origin, including ACTH,

insulin, numerous liver extracts, trypsin, thyrotropin and others. The visitors were interested in the special section set aside for the production of gamma globulin and serum albumin from human blood, all of which is taken over by the government for distribution. The extraordinary precautions to insure sterility of parenteral material impressed many of the physicians especially.

The beautiful plant is strung along a two-story corridor a quarter of a mile long, and among those who walked its length twice was the ninety-year old Dr. William A. Dicus of Streator, Illinois' 1953 outstanding general practitioner.

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## **LET'S HAVE YOUR NAME DOCTOR**

The Scientific Service Committee of the Illinois State Medical Society has been authorized by the Council to revise the List of Speakers available to county medical societies.

All physicians wishing to be included are urged to send in their names together with a list of the subjects for which they would be available. In instances where physicians are not connected with a teaching position at a medical school, the hospital staff affiliation should be included. Mention should also be made of the type of slide used in talks, and titles of movies if available.

The List of Speakers has not been revised since 1947. In 1950 a mimeographed Supplementary List was assembled, but the Scientific Service Committee hopes to compile a new and timely booklet which will include the advances made in the last few years.

Plans are to enlist the aid of every county society in submitting names of physicians who wish to participate in the activities of the Scientific Service Committee.

Physicians individually are urged to submit their names directly to Dr. Louis R. Limarzi, Chairman of the Scientific Service Committee, Illinois State Medical Society, 185 North Wabash Avenue, Chicago 1, Room 801.

# MEDICAL ECONOMICS

**The Medical Economics Committee. John R. Wolff, Chairman, Walter C. Bornemeier, Edward W. Cannady, Roland R. Cross, Jr., E. F. Dietrich, W. W. Fullerton, Edwin F. Hirsch, Frederic T. Jung, W. R. Malony, Caesar Portes, William Requarth, Frederick W. Slobe.**



## Deadline Medicine

**Mr. Edward Lindsay,  
Editor, Lindsay-Schaub Newspapers  
Decatur**

As I think back over a good many years in the newspaper business, I am astonished at the mutual distrust of newspaper men and doctors in the reporting of medical news.

The fault has been on both sides.

Doctors are scientists and, therefore, are devoted to the discovery of the exact truth.

Newspaper men are reporters and, therefore, must address themselves to the approximate truth now.

In his day-to-day practice, the doctor is inclined to approach diagnosis tentatively, recognizing the possibility that his first impression might be proved wrong by further developments or additional tests.

Publication, in the doctor's training, is a major conclusion to be considered only after long observation of the reactions of many patients to particular treatment. This is serious business and is undertaken guardedly in a restricted audience. Publication to the doctor, might be a paper read before his hospital staff, his medical society or possibly an article for a medical journal.

Publication to the newspaper man is answering in the next edition, all of the questions of a mass audience about some striking occurrence. He has learned that news is the world's most perishable commodity. It is gathered at great expense and loses its value as soon as it becomes generally known.

The paths of doctors and newspaper men cross in connection with a large number of occurrences in which the public is interested: births, deaths, accidents, crimes involving physical violence, the serious illness of prominent citizens, the discovery of new medicines and treatments.

During the dark days of medico-press relationship, which existed throughout most of my life, our newspapers have often been guilty of, to say the least, undignified behavior in getting stories they felt they had to print.

More news came from ambulance drivers and nurses—and sometimes from the observations of reporters themselves posing as ambulance

drivers in emergency receiving rooms and corridors of hospitals—than from doctors.

On one occasion, a prominent citizen, actually suffering from delirium tremens, was reported to be hospitalized after a heart attack. This on the basis of a report from a student nurse who was dating one of the reporters.

These were the days when a large number of people, including newspaper reporters, suspected that the silence of doctors and hospitals was motivated primarily by a desire to cover up mistakes. Stories were always going around the office about baby mixups in the maternity wards, about the holdup victim who had died because the surgeon had removed an appendix in probing for the bullet, about deaths resulting from failure to remove surgical pads before an abdominal operation was closed. If a heart patient died in a doctor's office, a reporter's first thought was to put in a call to see if a coroner's jury had been summoned.

The only "doctors" who would talk to reporters were osteopaths and chiropractors wishing to stir up a fuss about being barred from practice in local hospitals, or an occasional ill-advised M. D., of dubious reputation among his colleagues, who was willing to tell the newspaper about some new treatment with which he had had success.

Fortunately, during the years when our newspapers and most of the members of the medical society were at sword's point, a few of us had close personal friends among the leading doctors.

These men, dealing with us as individuals, not as newspaper men, performed a great and unsung service for the medical profession and the press by telling us the simple truth in answer to questions that perplexed us. They were the unofficial public relations committees who were protected with anonymity because they were unofficial and because they would be embarrassed among their fellows if it were known that they regarded newspaper men as friends.

It is possible for the medical profession to have a good press and for newspapers to have prompt and reliable medical news, including interesting, but sound, feature stories on new drugs and new treatments.

This must begin by the realization among

the doctors themselves that they must have a favorable public opinion in a democracy in order to have a favorable climate in which to practice private medicine. The public is not to be feared, but to be cultivated, and I don't mean patronized.

I can tell you out of a lifetime of experience that the public is fair, reasonable, and capable of surprising comprehension of even complicated scientific information that is presented directly, honestly, and simply.

A committee from any local medical society can lay the groundwork for good public relations with the newspapers by getting the top editorial management of the local press in for an evening or two of soul-searching discussion. It is certain that everybody present, from the press and the medical society, will be nursing a few old wounds. A little frank talk, based on specific situations, will be the beginning of mutual understanding.

This can be carefully nurtured into some kind of a formal pattern for the future.

Doctors will be surprised to discover that every newspaper feels some responsibility for the effect of what it prints. Few newspapers, for example, use the names of victims in rape cases or insist on publishing the news of attempted suicides, unless the attempt is as spectacular as a pretty girl's effort to jump out of a downtown building at high noon.

A surprising number of newspapers do not print news of sanity hearings or commitments. Not many newspapers try to get the news of births of illegitimate children.

Newspapers that are aware of the social importance of this kind of restraint are capable of understanding some of the difficulties with which a doctor is confronted in the release of medical news.

Almost all of the usual reasons for friction between doctors and the press can be eliminated by the sort of understanding that can be worked out by leaders of the local medical society and leaders of the local press.

In East St. Louis and Decatur such understandings have been written into a formal code that has been accepted by the doctors, hospitals and the press.

It is not possible to maintain a good press unless there is an active and interested public

relations committee of the medical society constantly available for consultation.

In such consultation, it is possible to develop the kind of news about the local medical community that is vitally important to the doctors and the hospitals and to the public. Here I have in mind stories about the special equipment in local hospitals, outstanding work that is being done by doctors with special training, all looking to a full and accurate picture of the community as a medical center.

It will be necessary to have a working committee to which the press can appeal for the release of news in the possession of members of the local society who may not be willing at first to cooperate. The assistance of such

a committee will be necessary, of course, in connection with the release in usable form of some of the most interesting papers given before hospital staffs and local societies.

It will take a good while, I suppose, to lift the almost universal taboo on the use of doctors' names in connection with reports of the condition of private patients where the doctors' names would add interest and authenticity to the stories.

I can't avoid thinking that this taboo is based more on professional jealousy than on medical ethics. Medicine is the only profession in which the name of the individual making a statement is regarded as a matter of delicacy. It is my hope that this, too, will pass.

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## WHO WANTS SECURITY?

A further important trend which has been observed in our modern culture, is the desire for emotional security. Before the last election, it was predicted that in times of prosperity, the party in power stays in power. This prediction was wrong. Why? Because a psychological factor was overlooked—that people in general want more than just financial security. They need emotional security as well. Applied to the medical field, it means that the technological assurance, the mastery of x-ray machines and anti-biotics, while highly desirable, is not enough. We often overlook the fact that progress does not take the place in a straight

ascending line, that a much more correct picture is one of a spiral development. While it seems logical that progress has such a steady development, that greater and greater efficiency and scientific expertness on the part of the doctor was all that was demanded, our studies show conclusively that not only in this field, but in many other fields, people really want to be assured of the return of this spiral development. They want to come back to the kind of relationship on an emotional level that they used to have with their doctor. But in a more developed and scientifically more dependent form. *Ernest Dichter, Ph.D., Do Your Patients Really Like You? New York Medicine, October 20, 1953.*

## THE P.R. PAGE



### John W. Neal Resigns

First some bad news: John W. Neal, after twelve years of noteworthy service, presented his resignation as general counsel to the Illinois State Medical Society and executive secretary of its Committee on Medical Service and Public Relations, effective January 1. The resignation was accepted by the Committee and Council with many expressions by council members of sincere regret and of appreciation of the work he has done for the Society, especially in Springfield. The Council, by resolution, left it to the Committee to bring to the next meeting, March 14, its recommendations for filling the large gaps Jack's departure leaves in the Society's organization.

### P.R. Pamphlet Demand Rising

The new pamphlet on public relations for county medical societies, published two months ago by this committee, has stirred up much interest — not all in Illinois. Sample copies were sent to officers of all county societies and already about thirty have returned the enclosed post card asking for more than 500 additional copies.

The A.M.A. plans to send out additional samples to the mailing list of the "P.R. Doctor," and has assigned a staff writer to do a similar job.

Several state societies, which have felt the

need for such a rule and guide for their county P.R. chairmen, have indicated plans for their own pamphlets. One P.R. director, pocketing several copies in Illinois headquarters at St. Louis, said frankly that he was going to "steal most of it" for his state. He is welcome, of course; it's all for the good of the order.

The committee still has copies of the pamphlet on hand from the first printing and will send as many as desired on demand.

### Winnebago Training Plans

The Winnebago County Medical Society has two major events on report.

First, it opened January 1 two 52-week T.V. programs, one on each of Rockford's two stations, along health education lines, with the assistance of the state society's Educational Committee.

Second, it is planning for the spring a training course for new medical secretaries, which will cover not only the handling of patients in the office, but medical terminology, bookkeeping and other subjects the medical secretary needs to know. The ingenious phase of the Winnebago plan is the fact that the course will be given in co-operation with a business school in Rockford.

For secretaries already at work, the Winnebago society also is working up a special eight-week course of "post graduate" study on telephone techniques, bookkeeping and office-level public relations.

## Change in Ethics

Two actions of interest to public relations chairmen were taken at the A.M.A. meeting in St. Louis last month.

1. The House of Delegates adopted a resolution calling on the Board of Trustees to appoint "a special committee with broad representation throughout the profession" to study all aspects of the problems created in recent months by adverse publicity.

The resolution, presented by Oklahoma, pointed out that "published statements of certain medical spokesmen concerning alleged unethical practices of members of the medical profession have tended to destroy the confidence of patients in their physicians.

The Board of Trustees is to report on its findings and recommend corrective measures, if they deem it necessary, at the next meeting of the House of Delegates in San Francisco in June, 1954.

2. The House also approved a new version of Chapter 1, Section 5 of the "Principles of Medical Ethics," spelling out in more detail the extent to which physicians may go in providing information for the press and other media.

The essential part of the rewritten section follows:

"An ethical physician may provide appropriate information regarding important medical and public health matters which have been discussed during open medical meetings or in technical papers which have been published, and he may reveal information regarding a patient's physical condition if the patient gives his permission, but he should seek the guidance of appropriate officials and designated spokesmen of component or constituent medical societies. Spokesmen should be empowered to give prompt and authoritative replies and a list should be issued which identifies them and discloses the manner in which they may be reached. These provisions are made with full knowledge that the primary responsibility of the physician is the welfare of his patient but proper observation of these ethical provisions by the physician concerned should protect him from any charge of self-aggrandizement.

"Scientific articles written concerning hospitals, clinics or laboratories which portray clinical facts and technics and which display ap-

propriate illustrations may well have the commendable effect of inspiring public confidence in the procedure described. Articles should be prepared authoritatively and should utilize information supplied by the physician or physicians in charge with the sanction of appropriate associates.

"When any sort of medical information is released to the public, the promise of radical cures or boasting of cures or of extraordinary skill or success is unethical.

"An institution may use means, approved by the medical profession in its locality, to inform the public of its address and the special class, if any, of patients accommodated."

## Macon's Insurance Meeting

Macon County, intensifying its long-range public relations program, set up a society dinner meeting in December at which Dr. Everett P. Coleman of Canton, former state president, spoke on "What Organized Medicine Means to You." This was followed with a panel discussion with Dr. Coleman, Dr. Arthur F. Goodyear, 7th district councillor, Dr. Irving H. Neece, former councillor and state president, and Dr. Lee Frech, answering penetrating questions. The questions were presented by a second panel composed of Dr. F. Glenn Irwin, new president, Dr. Morris Murfin, new president-elect and Mrs. Clarence McClelland, president of the Macon County Woman's Auxiliary. Dr. C. Elliott Bell, retiring president and P.R. chairman, acted as moderator.

Macon County, with the approval of the state council, is also planning a big health insurance conference in April, with the co-operation of various elements in the Decatur community — insurance, labor, press, industry, hospitals, nurses, social service and the public. The many data collected in recent analyses of available insurance will be presented and the whole effort will be part of the society's plan for a health insurance drive.

Macon plans also to invite every county society in Illinois to send representatives to the meeting, in the belief that its material will be of equal value to other communities facing similar problems.

# KNOW YOUR SOCIETY



## COUNCIL COMMITTEES — (Continued)

This month the first Council Committees to be considered are the *Journal Committee* and the Editorial Board. Under the Constitution and By-Laws the publication of the Journal is a responsibility of the Council. The Council appoints the editor and the assistant editor, the Journal Committee and the Editorial Board, and each is responsible to the Council for its activities and actions.

The Journal Committee and the Editorial Board have a Damon and Pythias relationship; they hold joint meetings with one or the other of the chairmen presiding; motions are made by a member of one committee and seconded by a member of the other; papers submitted for publication are discussed before the joint group; changes in Journal format are presented to the joint session; suggestions come from all present.

The advertising is considered carefully after preliminary investigation by the business manager; new contracts are approved by the joint session. When papers are submitted for publication, any member of the board interested in the specialty presented, is asked for his opinion.

The Journal is published for the general practitioner, and for the average member of the Illinois State Medical Society, to keep him informed of Society activities, to give him an opportunity to read a general summary of the

minutes of the Council meetings; to present for his consideration problems in the field of medical economics, medical public relations, editorial comment, and first and foremost present for him in readable style the best scientific material available for publication in Illinois.

May we take this opportunity to ask that all county medical societies submit news items for publication in NEWS OF THE STATE, so that this section of the Journal may be kept up to date and interesting as a clearing house of grass roots activity throughout the state. Thank you.

*Maternal Welfare Committee.* The Maternal Welfare Committee has 11 members, one from each Councilor District in the State Society. Alternates from each district are also appointed, and are asked to serve when it is impossible for the regular member of the committee to function. All members are physicians interested in obstetrics and gynecology; some of them are specialists in this field. The material and infant mortality in Illinois is the prime concern of the committee, and its work centers around the ever-continued fight to bring better obstetrics and better infant care to every part of this state.

All infant and maternal deaths are investigated by the Committee. The files are kept secret; names are not disclosed — but the work goes on through the years. The reports of the Department of Public Health reflect the activities and the continued vigilance of this group, and the

cooperation of the Department has been another example of the excellent work of the Director, Dr. Roland R. Cross, and members of his staff. Members of the Illinois State Medical Society benefit directly (as do the residents of the State) from the statistics studied, the cases analyzed, and the findings made available for members of the profession.

This committee deserves your sincere admiration and appreciation. It is another service maintained by the Society with funds available because of the dues paid by each member. — Again, this is just one of the things you “get for your dues”, and as a member, an activity with which you should be familiar.

*Medical Economics Committee.* The Medical Economics Committee could be considered as a sub committee of the Editorial Board and the Journal Committee. Its main function is to provide articles and material for publication in the special section of the Illinois Medical Journal devoted to the problems in medical economics. The economic field of medicine has grown in stature, has become an integral part of the practice of medicine. All of the articles published in this section of the Journal represent work by members of the Society asked to function on this Commit-

tee. All of them are good; some of them have been outstanding. It will pay dividends in knowledge and up to date information if all recipients of the Journal will check through this section each month as it is published.

*Committee on Medical History.* The Committee on Medical History is concerned with the compilation of historical data to be kept on file permanently at the John Crerar Library, Chicago, as the depository. These data include biographic material on individual physicians; historical background on various county societies, and various district societies throughout the state; development of hospital care in Illinois; progress in scientific fields made by Illinois physicians; the historical actions of the State Society through its 114 years; pictures of individuals and events; the collection of historic books published in the fields of medicine and surgery, etc.

At the present time, the members of this committee have contributed chapters dealing with the various phases of medicine up to 1900, and the committee has fortunately secured the services of Dr. D. J. Davis, (permanent historian of the society) to act as the editor of the Second

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## THE PHYSICIAN AS PATIENT

With regard to this point of anxiety and fear concerning heart disease, there is one more thing that I should like to remind you of and that is that we as physicians are in no wise immune to this very prevalent condition. Take the doctor who is just at the peak of his career, in his forties, when life is said to really begin. He is awakened some hours after retiring, not by that essential annoyance, the telephone, but by a vague, oppressive sensation in the substernal region. It is not necessarily agonizing, in fact it is not severe at all. Yet it is there and unrelenting. Then the wheels go round and round and he starts some of his high-powered rationalizing. Maybe it was because he had had to hurry through the evening meal too rapidly, or perhaps it was the onion in the salad. But it is still there, no mistake in that. He takes a deep

breath, sits up on the side of the bed, stretches his arms about and then it goes away. But somehow he feels a bit insecure and he is far more concerned about this little experience than he would have been had the pain been somewhere else even though it had been twice as severe. You see, when we experience any sort of sensation, however vague, that we think could possibly have been our heart, our reaction to it is far different than to something much more severe, so far as pain is concerned, anywhere other than where we would expect heart pain to be. Such an experience makes its mark even on the impregnable constitution of the physician himself. Remember this the next time one of your patients tells you of a similar experience of his. *Paul Simpson, M.D., Some Aspects of Heart Disease From the Viewpoint of the Patient. J. Ky. State M.A., November, 1953.*

# CORRESPONDENCE



## CLINICS FOR CRIPPLED CHILDREN LISTED FOR FEBRUARY

Twenty clinics for Illinois' physically handicapped children have been scheduled for next month by the University of Illinois Division of Services for Crippled Children. The Division will count 15 general clinics providing diagnostic orthopedic, pediatric, speech and hearing examinations along with medical, social and nursing services. There will be 4 special clinics for children with rheumatic fever and 1 for cerebral palsied children.

Clinics are held by the Division in cooperation with local medical and health organizations, both public and private. Clinicians are selected among private physicians who are certified Board members. Any private physician may refer to or bring to a convenient clinic any child or children for whom he may want examination or may want to receive consultative services.

The February clinics are:

February 2 — Macomb, Marietta Phelps Hospital

February 3 — Hinsdale, Hinsdale Sanitarium

February 4 — Litchfield, St. Francis Hospital

February 9 — East St. Louis, Children's Welfare Hospital

February 9 — Peoria, St. Francis Children's Hospital

February 11 — Elmhurst (Rheumatic Fever), Memorial Hospital of DuPage County

February 11 — Springfield, St. John's Hospital

February 11 — Tuscola, Court House

February 12 — Chicago Heights (Rheumatic Fever), St. James Hospital

February 16 — Vandalia, American Legion Building

February 17 — Carrollton, Carrollton Grade School

February 17 — Chicago Heights, St. James Hospital

February 18 — Rockford, St. Anthony's Hospital

February 23 — Effingham (Rheumatic Fever), Douglas Township Building

February 23 — Peoria, St. Francis Children's Hospital

February 24 — Elgin, Sherman Hospital

February 24 — Springfield (Cerebral Palsy), Memorial Hospital

February 25 — Anna, New City Hospital

February 25 — Bloomington, St. Joseph's Hospital

February 26 — Chicago Heights (Rheumatic Fever), St. James Hospital

## THE AUXILIARY'S PART IN CIVIL DEFENSE

Civil Defense is a means of saving lives—yours and your family's—protecting and saving your property and Public properties. It means keeping production of food and supplies going in spite of atomic, biological or chemical attack. It affects each and everyone of us, whether we are urban or rural dweller.

Immediately we ask ourselves, what can we as individuals, or as an organization do to help in case of an attack. As an organization we can stress preparedness on the part of each individual, and the part we would play in the overall picture. As individuals, we may think we can do nothing—but let us not overlook this fact. 60% of all Civil Defense jobs can be performed by women. We, as a medical auxiliary, are unique in that we are all the wives of doctors. We come in contact with medicine and medical problems each time we answer the phone for our husbands. It was disclosed by the survey made of the Woman's Auxiliary to the Illinois Medical Society, that almost 50% of them are former nurses, technicians, etc. The other 50% were almost entirely composed of secretaries, teachers, etc. In a membership of almost 3000 women in Illinois, so educated, we have a tremendous source of available help—help that is vitally needed in Civil Defense. It behooves each and everyone of us to avail ourselves of all the knowledge available about Civil Defense and set the example for other organizations. After all the greatest load of the attack would have to be carried by the medical profession and we must be willing and able to step in and do our part. The lay person always expects us to be able to help them in an emergency, but how can we, if we don't educate ourselves to the facts of Civil Defense?

Each auxiliary should sponsor a Civil Defense Program at one of their meetings and ask the President of their Medical Society and Civil Defense Director of their District to speak on this subject. Then they can proceed within their own organization to perfect their own plan in case of an attack, and know that they will be able to give their help and assistance where it will be needed the most.

Mrs. Leonard J. Houda  
Chairman, Civil Defense

## WOMAN'S AUXILIARY BULLETIN

The Bulletin of the Woman's Auxiliary to the American Medical Association was established in 1939 under the supervision of the Advisory Council of the American Medical Association. It was to be the official publication of the Auxiliary to provide information to officers, chairmen and members. This it has done most successfully.

The purpose of the Bulletin is educational. It strives to be a source of information for the working members of the Auxiliary who wish to know more about their organization and to learn how they can best serve its interests.

County officers and chairmen find it a working tool. It answers the many questions that come up during a term of office. For example, a county president meets a challenge from reading the Bulletin. She learns what others are doing and so is inspired to raise the standard of her own county auxiliary.

The Bulletin is published quarterly—March, May, August and December.

The March issue is devoted to current national conferences of a medical nature and other informative material. The May issue contains the National Auxiliary convention program. The August number is a very important one to County Auxiliaries as it contains suggestions for chairmen. The December issue gives details regarding the November Conference for State Presidents and Presidents-Elect.

Mrs. James P. Simonds of Chicago is chairman of the National Publications Committee and has been for many years. Much credit is due her for her untiring work in editing the Bulletin.

It is the hope of the Auxiliary that every member will subscribe to the Bulletin. The price has always remained the same — \$1.00 per year. If you do not have a County Bulletin Chairman send your subscription to the Woman's Auxiliary to the A.M.A., 535 No. Dearborn St., Chicago, Ill.

Mrs. E. M. Egan, Co-Chr. Publications  
Woman's Aux. to the A.M.A.

## GRANTS-IN-AID, CANCER RESEARCH

The American Cancer Society, Illinois Division, Inc., has been the beneficiary of several legacies and has, therefore, limited funds which it is desired to expend for the support of responsible cancer research projects. Accordingly,

applications will be received for grants-in-aid for cancer research to be considered by a special committee.

Application forms may be obtained from John A. Rogers, M.D., Executive Director, American Cancer Society, Illinois Division, Inc., 139 North Clark Street, Chicago.

Applications should contain full details concerning the nature of the project and what is hoped in the way of accomplishment. Sufficient information should be supplied to assure the committee that personnel concerned in the research is qualified and that adequate facilities are available.

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## **SECOND NATIONAL CONFERENCE ON TRICHINOSIS**

The Second National Conference on Trichinosis will be held at the auditorium of the American Medical Association, 535 North Dearborn Street, Chicago, on Monday, March 1, 1954. The purposes of the conference are to discuss methods of education, problems of human and animal health, and research in relation to this disease. Physicians interested in attending this conference should get in touch with S. E. Gould, M.D., Chairman, Continuing Committee on Trichinosis, Eloise, Michigan.

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## **AEC OFFERS EIGHT FELLOWSHIPS IN INDUSTRIAL MEDICINE**

Eight fellowships in industrial medicine will be offered by the U.S. Atomic Energy Commission for the 1954-1955 academic year. The fellowship program, begun by the AEC four years ago, is designed to provide advanced training and on-the-job experience for men and women physicians in the field of industrial medicine, particularly in relation to the atomic energy industry.

The fellowships are open to United States citizens who hold M.D. degrees from approved medical schools, and who have had at least one year of internship. In exceptional cases, equivalent experience may be accepted in lieu of the internship requirement. Successful candidates must be investigated by the FBI and approved by the AEC before receiving fellowships.

Awards are for one year's academic training at institutions offering approved graduate courses in industrial medicine which can provide special

training facilities in the health problems associated with the atomic energy program. Normally, fellows will be eligible for a second, or in-plant, training year upon successful completion of the academic year. In-plant training will be given in medical departments of major AEC plants and laboratories.

There is a critical need for qualified industrial physicians in atomic energy installations, and at the end of the two-year training period fellows may find employment in the program. However, there will be no commitment on the part of the AEC to continue the applicant's training beyond the first year or to provide employment for him upon the completion of training. Fellows will not be obligated to take the second year of training or to seek employment with the AEC or its contractors.

The stipend during the first year is \$3,600, with \$350 additional for a wife and for each dependent child. Tuition and laboratory fees will be paid. The stipend for the second year is \$6,000, with no additional amounts for a wife or children.

The program is administered for the AEC by the Atomic Energy Project of the School of Medicine and Dentistry, University of Rochester, Rochester, New York. Fellows are selected by a committee headed by Dr. Robert A. Kehoe, Director, Institute of Industrial Health, University of Cincinnati, and Medical Director, Ethyl Corporation.

Applications for 1954-55 fellowships should be submitted by January 1, 1954 to: AEC Fellowships in Industrial Medicine, Atomic Energy Project, University of Rochester, School of Medicine and Dentistry, Rochester, New York. Attention: Dr. Henry A. Blair.

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## **NEW TYPE NAVAL RESERVE UNIT FOR PHYSICIANS**

A new type reserve unit for Naval Reserve Doctors and other members of the Medical profession is being organized in Chicago, it was announced by Rear Admiral Francis P. Old, Commandant of the Ninth Naval District. The new unit, to be called Naval Reserve Surface Division (Medical) 9-240 will meet at Veteran's Research Hospital, newly-completed skyscraper medical center, located near the Downtown Campus of Northwestern University.

Doctors, medical-specialists, veteran Navy

Hospital Corpsmen and administrative personnel are eligible to belong to this reserve unit which provides one day's pay for each drill attended. There are 48 scheduled drills per year. This is the first time Navy medical reservists have been able to join a paid reserve unit with regularly-scheduled drill periods, and definite curricula for its participants.

The Chicago Naval Reserve Medical Surface Division is one of five which have been established in a test program, Admiral Old pointed out. Other units have been set up in Boston, New York, Charleston, S. C., and San Francisco. If these test units prove successful the program will be extended to other major cities of the country, he added.

Officers eligible for the Chicago Naval Reserve medical unit must be members of the Navy's medical corps, and its medical specialist branch. They must be in the grades from lieutenant (junior grade) through Commander. Enlisted personnel, include hospitalmen, yeomen, personnelmen, and storekeepers.

Chicago was chosen as one of the original test sites for this type training because of the large number of doctors and medical specialists available, and because of the outstanding medical facilities of the region.

Officers and men of Chicago and its suburbs who are interested in affiliation with the new Naval Reserve Medical Surface Division should call Captain Fred Fluegel, USN, Commanding Officer of the Naval Reserve Training Center, Foot of Randolph street for details. His phone number is CEntal 6-6828.

### **INTERNATIONAL GROUP OF DOCTORS IN ALCOHOLICS [ANONYMOUS]**

The "Fifth Annual International Group of Doctors in Alcoholic Anonymous, Mayflower Hotel, Akron, Ohio, May 14, 15 and 16, 1954. For information and reservations address: Doctors, Mayflower Hotel, Akron, Ohio."

This group of doctors in AA was formed five years ago with a few men from Western New York State. Last year we had men present from as far south as Florida and as far west as Colorado. There are no doubt men in your state who would appreciate knowing about this meeting that we could not otherwise contact than through your medical journals.

### **AMERICAN FOUNDATION FOR ALLERGIC DISEASES**

The American Foundation for Allergic Diseases has been established with offices at 525 Lexington Avenue, New York City, under the joint sponsorship of the American Academy of Allergy and the American College of Allergists, according to an announcement from Foundation headquarters.

The Foundation is incorporated under the laws of New York State as a national, non-profit, voluntarily supported organization. Under the articles of incorporation its aims are: To promote through public education an accurate understanding of the problem of the allergic diseases; to inform and educate the medical profession in the problems of allergy; to cooperate with medical institutions, hospitals and other organizations for the development of facilities for the treatment and prevention of allergic diseases; and to provide facilities for research including fellowships and residencies.

The officers and trustees of the Foundation are as follows: President, Horace S. Baldwin, M.D. New York; vice-president, J. Warrick Thomas, M. D., Richmond, Va.; secretary, Bret Ratner, M.D., New York; treasurer.

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### **POSTGRADUATE COURSE ON DISEASES OF THE CHEST**

The Council on Postgraduate Medical Education of the American College of Chest Physicians, in cooperation with the respective state chapters of the College as well as the staffs and faculties of the local hospitals and medical schools, will sponsor the Second Regional Postgraduate Course on Diseases of the Chest in New Orleans, Louisiana, February 15-19, 1954 and the Seventh Annual Postgraduate Course on Diseases of the Chest to be held at the Bellevue-Stratford Hotel, Philadelphia, Pennsylvania, March 15-19, 1954.

These postgraduate courses endeavor to bring physicians up to date on recent advancements in the diagnosis and treatment of heart and lung disease. Tuition for each course is \$75.

Further information may be secured by writing to the Executive Director, American College of Chest Physicians, 112 East Chestnut Street, Chicago 11, Illinois.

# NEWS OF THE STATE



## ADAMS

**Regional Heart Conference.**—The Illinois Heart Association sponsored a regional clinical conference at the Lincoln-Douglas Hotel, Quincy, on November 19. Among the speakers were Drs. Richard E. Dukes, Urbana, on "Problems in the Care and Treatment of Rheumatic Fever;" Banning Lary, Chicago, on "Recent Development in the Treatment of Vascular Diseases;" Henry A. Schroeder, St. Louis, on "New Aspects in the Treatment of Hypertension." A panel discussion was a feature of the meeting participated in by Drs. Richard E. Dukes, A Carleton Ernstene, Banning Lary and Henry A. Schroeder. Walter M. Whitaker, Quincy, was the moderator. In the evening, Dr. J. L. Rouner, Quincy, presided at dinner. Dr. Warren F. Pearce, Quincy, president of the Illinois Heart Association, discussed the "Program of the Illinois Heart Association and How It Serves the Physician" and Dr. Ernstene, Cleveland, spoke on "Coronary Heart Disease."

**Physicians at Boy Scout Camp.**—The Quincy Medical Bulletin announces that the following physicians assisted in the local boy scout camp this past summer: Drs. Hilliard M. Shair, Newton DuPuy, C. W. Hagler, James H. Cravens, Edgar H. Keys, Jr., Daniel Liang, George Borden, Roger G. Clarke, Harry G. McGavran, and Charles E. Richards.

**Seventy-Five Years As A Physician.**—The Quincy Medical Bulletin for November contains a review of his seventy-five years as a physician by Dr. Edmund B. Montgomery. Dr. Montgomery received his doctor of medicine degree at Jefferson Medical College in 1878 and an honorary doctor of science degree in 1953. In addition to commenting

on his various travels about the country, Dr. Montgomery said that he was active in medical society work, serving as secretary of the Adams County Medical Society from 1880 to 1890 when he became president. He was officer of the Military Tract Medical Society in 1885, member and officer of the Illinois State Medical Society for many years beginning in 1880, as well as having contributed extensively to the medical literature in the subsequent years. He recalled his work with Kelly in the preparation of the dictionary, titled "American Medical Biography."

He was a delegate to the International Medical Congress in 1906 at Lisbon, Portugal. He is credited with being a founder of the American College of Surgeons and, up until the time he reached seventy years of age, was active as an insurance examiner. Many recognitions and honors have been received by Dr. Montgomery, he recalls.

**Nuns Honor Staff Physicians.**—The Sisters of St. Mary's Hospital held a banquet in honor of members of the medical staff who have served the hospital for twenty-five years or more, and who had not previously been so honored, according to the Quincy Medical Bulletin. Those honored in order of their seniority were Drs. Franklin T. Brenner, John E. Miller, Richard A. Harris, Norbert A. Blickhan and Milton E. Bitter. Each honored guest received a gift from the nuns and the toastmaster for the evening was the staff secretary, Leroy M. Wolfe, D.D.S.

**Society News.**—At a recent meeting of the Adams County Medical Society, Dr. Fred L. Stuttle, Peoria, spoke on the need for cooperation between the physicians and the physiotherapy department of Blessing Hospital.

## CLINTON

**Society News.**—Dr. Harold K. Roberts, St. Louis, addressed the Clinton County Medical Society at its October 14 meeting in Breese. His subject was "The Management of Diabetes."

## COOK

**McCormick Gift Furthers Realization of Passavant Wing.**—A gift from Col. and Mrs. Robert R. McCormick to the Passavant Hospital Building Fund was announced, November 11. The gift is in the form of Florida real estate and is for the unrestricted use in the hospital's expansion project, according to the Chicago Tribune. The real estate is valued at approximately \$225,000. While the hospital is now engaged in a \$3,000,000 campaign to raise funds to finance construction of a one hundred bed addition, the recent gift helps the launching immediately of work on the architect's plans.

**Children's Center Opened.**—Formal ceremonies, with Cardinal Stritch presiding, featured the dedication of the new Children's Center at the Schultz Memorial Auditorium at St. Francis Hospital, Evanston. The five rooms now being remodeled in the Children's Center, will, it is reported, provide coordination of the specialists' work in the treatment of children with deformities, now being conducted in scattered locations throughout the city. When completed, the Center will contain a minor surgery room, two dental rooms, X-ray room, and a dental laboratory. The Schultz Memorial Auditorium is located in the newly constructed interns residence. It is named in memory of Dr. Oscar T. Schultz, who had been pathologist at the hospital for many years prior to his death in 1947.

**Branch Meetings.**—The North Side Branch of the Chicago Medical Society, at its meeting in the Drake Hotel, November 5, presented the following program: Dr. Leo L. Hart, "Telangiectasis of the Gastrointestinal Tract with Massive Hemorrhage"; Dr. Max Montgomery, "Treatment of Rheumatoid Arthritis"; Dr. Fremont A. Chandler, "Lower Back Pain in Older People"; Dr. Charles B. Puestow, "Benign Pancreatic Disease"; Dr. Walter G. Maddock, "Electrolyte Metabolism in the Pre- and Post-operative Periods"; Dr. Lloyd A. Gittelsohn, "Anesthesia in the Elderly Patient", and Dr. Jack Williams, "The Diagnosis of True Posterior Infraction by Scapular Leads."—The North Suburban Branch of the Chicago Medical Society was addressed November 9 in the Community House of the First Methodist Church, Evanston, by Drs. Herbert H. Stark, resident in orthopedic surgery, St. Francis Hospital, on "Unusual Locations and Manifestations of Xanthomatous Tumors", and Edmund F. Foley, professor of medicine, University of Illinois College of Medicine, "Nutritional Aspects of Liver Disease."—The North Shore Branch was addressed at the Edgewater Beach Hotel, December 1, by Jay M. Garner, on "Proctoscopic Clinic in Color Movies" and J. P. Nesselrod who also assisted in

the same movie demonstration. Dr. Samuel M. Feinberg spoke on "Iatrogenic Allergy—A Problem for Every Practitioner." The Branch was addressed November 3 by Dr. Eugene McEnery on "Unexpected Conditions in Infancy" and Dr. Carlo Scuderi on "Backache, Its Diagnosis and Treatment."

**Dr. Elvehjem Gives Dickinson Lecture.**—The second Albert Dickinson Memorial Lecture was delivered by Conrad A. Elvehjem, Ph.D., professor of biochemistry and Dean of the Graduate School of the University of Wisconsin, Madison. The lecture was presented under the auspices of the Chicago Academy of Sciences and was given in the Albert Dickinson Hall at the Academy, November 20. The title of Dr. Elvehjem's lecture was "Nutritional Interrelationships."

**Medical Fellowships Awarded.**—Fellowships to the American Academy of Pediatrics were awarded recently to Drs. John M. Reicher and Sidney W. Robin. To qualify for the fellowships, a physician must have at least five years of specializing in infant and child care after completing an internship.

**Panel on Hypertensive Cardiovascular Disease.**—On November 17, a panel on hypertensive cardiovascular disease featured the meeting of the scientific section of the Chicago Heart Association program. Dr. George E. Wakerlin, who acted as moderator, spoke on "Pathogenesis of Hypertension"; Dr. Loyal Davis, "Treatment of Hypertension from a Surgeon's Viewpoint," and Dr. T. N. Pullman, "Treatment of Hypertension from an Internist's Viewpoint." Other participants were Drs. Louis N. Katz and William A. Thomas. Dr. Katz spoke on "The Natural History of Untreated Hypertension."

**Beatrice Wade Honored.**—Miss Beatrice D. Wade, associate professor of occupational therapy and head of the department, University of Illinois College of Medicine, was honored November 4 at a tea observing the tenth anniversary of the establishment of her curriculum in the medical school. The tea was attended by members of the faculty, students, and alumni of the occupational therapy curriculum. Miss Wade was presented with a gift. According to the news release from the University of Illinois, Miss Wade established the occupational therapy program at the University of Illinois College of Medicine in 1943, which was said to be the first occupational therapy curriculum in the United States to be associated with a medical school. Since its establishment, 118 students have received the bachelor of science degree, while sixty-seven others were awarded a certificate in occupational therapy during World War II.

**Personal.**—Dr. Meyer A. Perlstein, assistant professor of pediatrics, Northwestern University Medical School, has been elected president of the American Academy for Cerebral Palsy, of which he is a founder in 1947. He has been serving as secretary of the organization since that time.

**Society News.**—At a meeting of the Chicago Rheumatism Society, October 28, Milton Engel, associate professor of orthodontia, University of Illinois Dental School, spoke on "Experimental Studies on the Dissolution and Calcification of Bone and Cartilage Matrix," and Jerome F. Strauss, Jr., clinical instructor in medicine at the University of Illinois College of Medicine, on "Prognosis of Lupus Erythematosus with Current Therapy."

**University Lectures.**—Two lectures at the University of Illinois College of Medicine recently were those presented by Dr. Bernardo A. Houssay, professor of physiology, University of Argentina, on "Preventive and Curative Actions of Some Steroids on Experimental Diabetes," and one by Dr. Paul C. Aebersold, director of isotope research, Atomic Energy Commission, Oak Ridge, Tennessee, on "Radioisotopes—Tools for Medicine." The latter was under the auspices of Phi Delta Epsilon.

**Gift Goes To Francis Lederer.**—The Otolaryngologic Alumni Association of the University of Illinois presented a suitably engraved silver cigarette box to Dr. Francis L. Lederer, professor and head of the department of otolaryngology at the medical school. Dr. Lederer had been named the outstanding teacher during the 1952-53 school year. The Association also presented to Dr. Cecil D. Riggs, a captain in the Medical Corps of the United States Navy, with an award as the outstanding resident during the school year. Dr. Riggs, currently stationed at the Naval Hospital in Oakland, California, also received a cigarette box in absentia. New officers of the Association are Dr. Albert H. Andrews, Jr., clinical assistant professor of bronchoesophagology in the department of otolaryngology, who was named president and Dr. Burton J. Soboroff, who was reelected secretary-treasurer.

**Course In Electrocardiographic Interpretation.**—Michael Reese Hospital offers a course in electrocardiographic interpretation for graduate physicians, beginning Wednesday, February 3. Subsequently the class will meet each Wednesday from 7:00 to 9:00 p.m. for twelve consecutive weeks. The course will be under the direction of Dr. Louis N. Katz, director of the cardiovascular department, Medical Research Institute, and associates. Additional information and a copy of the lecture schedule may be obtained by writing to Mrs. Rivian H. Lewin, administrative secretary, cardiovascular department, Medical Research Institute, Michael Reese Hospital, Chicago 16, Illinois.

**Dr. Abrams Joins Illinois Faculty.**—Dr. Herbert K. Abrams, medical director of Union Health Service, Inc., Chicago, has been appointed clinical assistant professor of public health at the University of Illinois College of Medicine. Dr. Abrams previously was chief of the Bureau of Adult Health, California State Health Department and taught at the University of California School of Public Health

and at San Francisco State College. He holds the doctor of medicine and master of science degrees from the University of Illinois, and the master of public health degree from Johns Hopkins University. He is certified by the American Board of Preventive Medicine and Public Health and is currently chairman of the Industrial Hygiene Section of the American Public Health Association.

**Personal.**—Dr. Percival Bailey, Chicago, has been appointed chairman of the Illinois Psychiatric Research Council. This appointment was made by the Governor.

**First Remer Lecture.**—Dr. Paul D. White, Boston, delivered the first annual Harry G. Remer lecture at the La Rabida Sanitarium, December 11. This was a public lecture and was titled "Rheumatic Fever." The lecture preceded the formal dedication, the following day of a \$300,000 addition to La Rabida. The sanitarium is devoted to the treatment and study of rheumatic fever. Funds for the new structure were made available by Albert Pick, Sr., Chicago philanthropist, who now lives in Miami Beach, Florida. The two story building will be known as the Gertrude Frank Pick Children's Center in memory of Mr. Pick's first wife who died in 1945. In addition to other services, the new building will house added research laboratories, examination rooms, occupational therapy quarters, and serve as a nerve center for La Rabida's expanded home service department aimed at combating rheumatic fever at its source—within the family, according to the Chicago Tribune. The new center will also contain a psychiatric clinic and consultation rooms for the instruction of parents.

**Grants for Research.**—Eli Lilly and Company, Indianapolis, Ind., has awarded three new research grants to the University of Illinois College of Medicine, Acting Dean Roger A. Harvey has announced. Dr. William R. Best of the Department of Medicine has received a \$5,400 grant for the study of the effect of drugs and hormones on the production of antibodies destructive to red blood cells in acquired hemolytic anemia. Lilly has awarded a \$2,000 grant to Dr. A. A. Schiller of the Department of Physiology for a study of the behavior of plasma proteins in the kidney. Dr. C. I. Reed of the Department of Physiology has received a grant in the amount of \$1,671 in support of a study of synovial membrane permeability.

**Appointments at Illinois.**—Appointment of three to the faculty of the University of Illinois College of Medicine with rank of assistant professor in the Department of Psychiatry has been announced by Acting Dean Roger A. Harvey.

Dr. Louis Lams and Dr. Raymond E. Robertson have received non-salaried appointments as clinical assistant professors. Dr. Jeanne Spurlock will serve the University on four-fifths time.

Dr. Lams, who is in private practice, will assist in the teaching program of residents and senior clerks. He holds the doctor of medicine and bachelor of arts degrees from the University of Toronto. He has been certified by the American Board of Psychiatry and Neurology in psychiatry.

Dr. Robertson recently was appointed as acting superintendent of the Institute for Juvenile Research, replacing Dr. Julius B. Richmond who resigned. The facilities and professional staff of the Institute for Juvenile Research are used in the University's training program in psychiatry. Dr. Robertson holds the doctor of medicine and bachelor of science degrees from the University of Chicago. He has been associated with the Institute for Juvenile Research since 1951.

Dr. Spurlock will work as a child psychiatrist on the children's psychosomatic ward, and will assist in the teaching of medical students, residents, and ancillary personnel. She has been associated with the Institute for Juvenile Research since 1950. She is a graduate of Howard University Medical School. Dr. Frank J. Fara has been appointed clinical assistant professor on the non-salaried staff of the Department of Obstetrics and Gynecology at the University of Illinois College of Medicine.

Dr. Fara presently serves as professor of obstetrics at the Cook County Graduate School of Medicine, and, prior to receiving the UI appointment, was associated with Northwestern University Medical School. He received both the doctor of medicine and bachelor of science degrees from the University of Illinois, and taught at the University between 1934 and 1936.

He is a member of the attending staff at Cook County Hospital, and chief and head of the Department of Obstetrics and Gynecology at Hospital St. Anthony de Padua. He also is affiliated with MacNeal Memorial Hospital, Berwyn, and Morris (Ill.) Hospital.

### LAKE

**Blood Bank License.**—The Bulletin of the Lake County Medical Society recently announced that the Jacob Blumberg Memorial Blood Bank has been licensed by the National Institute of Health.

**Society News.**—Dr. Arthur DeBoer, attending surgeon, Children's Memorial Hospital, Chicago, discussed "Surgical Correction of Cardiac Anomalies in Children" before the Lake County Medical Society at the Elks Club, Waukegan, November 17.

### KANE

**Personal.**—Dr. Alan Lieberman, retired November 30 as clinical director of the Elgin State Hospital to enter private practice in Elgin. He will continue as a consultant in psychiatry at the hospital. Dr. Werner Tuteur has been promoted to acting clinical director to succeed Dr. Lieberman.

### MACON

**Society News.**—Dr. Paul Hageman, department of medicine, Washington University School of Medi-

cine, St. Louis, addressed the Macon County Medical Society, October 27, at the St. Nicholas Hotel in Decatur. His subject was "Arthritis—Gout."

### MADISON

**Society News.**—Dr. James F. Dowd, senior instructor in surgery, St. Louis University School of Medicine, discussed "Plastic Surgery of the Hand" before the Madison County Medical Society at a meeting in the St. John's Methodist Church, Edwardsville, Thursday, December 3.

### PEORIA

**Society News.**—A symposium on diagnosis and treatment of congenital defects formed the November 17 meeting of the Peoria Medical Society in the Jefferson Hotel, Peoria. Participants were: Drs. Robert S. Easton, Robert DeBord, and Harrison C. Putman.

**Dr. Vonachen Honored.**—A citation for outstanding service in promoting the employment of physically handicapped persons was bestowed on Dr. Harold A. Vonachen, medical director of Caterpillar Tractor Company, Peoria, at a dinner sponsored by the Governor's Committee for Employment of the Physically Handicapped and the Disabled American Veterans at the LaSalle Hotel, Chicago, October 4. The citation honors Dr. Vonachen for his work in pioneering the "Peoria Plan for Human Rehabilitation," which, first launched in 1942, established a national pattern, with other cities and towns throughout the country sending medical, industrial, and civic representatives to Peoria to study means of applying the program to their own communities. Representatives also came from England, Canada, Czechoslovakia, and Belgium. An outgrowth of the Peoria plan, the Institute of Physical Medicine and Rehabilitation of Peoria, a nonsectarian organization of which Dr. Vonachen is president, was established in 1951. Dr. Vonachen was presented with the William S. Knudsen award (1943-1944) for "outstanding work in the development of a program for the employment of handicapped Caterpillar workers which laid the foundation for a community-wide human rehabilitation program called 'The Peoria Plan for Human Rehabilitation.'" The Disabled American Veterans also honored Dr. Vonachen with a certificate of merit.

**Forum on Medical Economics.**—A forum on medical economics was held at the Jefferson Hotel in Peoria, December 3, under the auspices of the Peoria Medical Society. The forum developed when representatives of the medical society, retail druggist association, hospital administration and directors of laboratory and x-ray services appealed to the Peoria Accident and Health Underwriters Association to obtain national authorities on medical economics. The program was presented by Dr. W. H. Scoins, chairman of the medical directors committee, Health and Accident Underwriters Con-

ference and also chairman of the medical liaison committee, Health Insurance Council; Mr. H. Lewis Rietz, president of the Health and Accident Underwriters Conference and Mr. James R. Williams, director of public relations, Health and Accident Underwriters Conference. The formal presentations were limited to fifteen minutes with forty-five minutes being devoted to the answering of questions by the panel. Special invitations were extended to members of the Peoria Medical Society, Tazewell County Medical Society, Woodford County Medical Society, Peoria Accident and Health Underwriters Association, Hospital Administrators, Retail Druggists, press and radio. According to an announcement from the Peoria Medical Society, this conference is believed to be the first of its type done on a local and postgraduate level. The announcement continued "True or not, it has been stated: '- - a practitioner who's so wrapped up in the clinical side of his practice that he just "hasn't time" to worry about the financial and public relations sides. His typist takes care of collections, setting some of the fees, and, as she puts it, "keeping the folks in line." This is the type of thoughtlessness that too many an honest physician is guilty of.' The best medical service is based on a friendly, mutual understanding between doctor and patient: *It is the physician's duty to explain to his patient just what he is receiving for his money, how he will benefit from the scientific advances of medicine, or how expensive it is to run a modern hospital with all its laboratory, x-ray, nursing and diet facilities.* A reliable yardstick for presenting information to the public is arrived at by comparative evaluation of nationwide statistics."

### ROCK ISLAND

**Society News.**—Dr. Coye Mason, pathologist at Grant Hospital, and instructor in the department of pathology at the University of Illinois College of Medicine, addressed the Rock Island County Medical Society, November 10, on "Blood Banks and Allied Problems."

### SANGAMON

**Interprofessional Officers.**—Dr. M. E. Rolens was elected president of the Sangamon County Chapter of the Illinois Interprofessional Council at a meeting in Springfield, October 22. Other officers are: Charles Delano, D. S. C., vice-president; W. H. Bachmann, Pharm.D., secretary; and Joseph Mayfield, optometrist, treasurer.

**Society News.**—Dr. Henry Schroeder, associate professor of medicine, Washington University School of Medicine, St. Louis, addressed the Sangamon County Medical Society, at a meeting in the Elks Club, November 5, on "Evaluation of the Newer Treatments of Hypertension." The society was recently addressed by Drs. L. H. Mayers and S. B. Herdman, both of Chicago, on "The Problem of the Adult Cripple." Dr. Edward A. King, radiologist, Memorial Hospital, Springfield, ad-

ressed the society at the Elks Club, December 3, on "The Human Application of Radioactive Isotopes."

### VERMILION

**Society News.**—"Estate Planning for Physicians" was the title of an address before the Danville Regional Chapter of the Illinois Academy of General Practice, at the Lake-View Hospital, Danville, November 19. The speaker was Mr. John A. Appelman.

### WINNEBAGO

**Personal.**—Dr. Warren C. Lewis has announced the opening of his office for the practice of internal medicine at 415 Nu-State Building, Rockford, Illinois.

**Society News.**—Dr. Manuel Lichtenstein, professor of surgery, Cook County Graduate School of Medicine and associate professor of surgery at Northwestern University Medical School, discussed "Gall Bladder Disease and Gall Bladder Surgery" before the Winnebago County Medical Society at its regular meeting at the Rockford Country Club, November 10.

Dr. W. W. Bauer, director of the Bureau of Health Education of the American Medical Association, Chicago, addressed the Society at its annual Christmas dinner, December 8.

### GENERAL

**Essay Award.**—The Board of Regents of the American College of Chest Physicians offers three awards to be given annually for the best original contribution, prepared by any medical student studying for the degree of Doctor of Medicine, on any phase relating to the diagnosis and treatment of chest disease. The first prize will consist of a cash award of \$250 and a certificate. The second and third prizes will be certificates of merit. The essay award is open to all medical students in accredited medical schools throughout the world. The winning contributions will be selected by a board of impartial judges and will be announced at the 20th Annual Meeting of the American College of Chest Physicians to be held in San Francisco, California, June 17-20, 1954. All manuscripts become the property of the American College of Chest Physicians and will be referred to the Editorial Board of the College journal *Diseases of the Chest* for consideration. The College reserves the right to invite the winner of the first prize to present his contribution at the Annual Meeting. Applicants are advised to study the format of its official journal as to length, form, and arrangement of illustrations to guide them in the preparation of the manuscript. The following conditions must be observed:

1. Five copies of the manuscript typewritten in English (double spaced) should be submitted to the Executive Director, American College of Chest

Physicians, 112 East Chestnut Street, Chicago 11, Illinois, not later than March 15, 1954.

2. The only means of identification of the author shall be a motto or other device on the title page and a sealed envelope bearing the same motto on the outside enclosing the name and address of the author.

3. A letter from the Dean or Chairman of the Department of Medicine of the medical school certifying that the author is a medical student studying for the degree of Doctor of Medicine and that the contents represent original work.

**News of Medical Writers' Association.**—Dr. Lee van Antwerp, Chicago, was named president-elect of the American Medical Writers' Association at its recent meeting in Springfield. Other officers are: Drs. W. W. Bauer, Chicago, and Stewart Wolf, Oklahoma City, first and second vice presidents respectively. Dr. Antwerp was also named editor. Dr. N. C. Barwasser, Moline, was named accounting officer and Dr. Harold Swanberg, Quincy, was reelected as secretary-treasurer. Dr. Jacob E. Reisch, Springfield, was installed as president. The Association's honor award, which is given from time to time "to a non-member of the Association who has made distinguished contributions to medical literature" was given to Dr. Bauer, editor of *Today's Health*. At the time he was nominated for the award, Dr. Bauer was not an active association member. The association's Distinguished Service Award, which is given annually to a member of the association "who has made distinguished contributions to medical literature or rendered unusual or distinguished service to the medical profession" was given to Dr. Julius Jensen, St. Louis, former president of the Association. The Association's Honor Award for Distinguished Service in Medical Journalism went to Dr. Thurston S. Welton of Brooklyn. Illinois physicians who were given certificates of fellowship in the Association "in recognition of high qualifications, personal and professional, and of established standing as a medical writer, journalist or publisher" included: Drs. Joseph E. Bellas, Peoria; Lloyd A. Gittelson, Chicago; John L. Keeley, Chicago; Roland I. Pritikin, Rockford; Jacob E. Reisch, Springfield; Dean Franklin Smiley, Chicago; Lee D. van Antwerp, Chicago; Theodore R. Van Dellen, Chicago and Arkell M. Vaughn, Chicago.

**Louis Newman Moves to Chicago VA.**—Dr. Louis B. Newman, since 1946 chief of physical medicine and rehabilitation service at the Veterans Administration Hospital, Hines, has been appointed to a similar capacity at the new 520 bed Veterans Administration Research Hospital, 333 East Huron Street, Chicago. The appointment was effective in October. Dr. Maxwell D. Flank is the acting chief of the physical medicine and rehabilitation service at Hines.

**Postgraduate Conferences.**—The Postgraduate Education Committee of The Illinois State Medical Society in co-operation with the staff of The Veterans' Administration Hospital at Hines, Illinois, presented a postgraduate conference at Taylorville, Illinois, December 10, 1953. The Christian County Medical Society was host.

Speakers included: Lyle A. Baker, M.D., Edward O. Willoughby, M.D., Ervin Kaplan, M.D., William J. Gillesby, M.D., and A. Zerneck Chapman, M.D. They presented three panels on "The Management of Thyroid Disease," "Management of Gastrointestinal Hemorrhage," and "Management of Blood Disorders," with Dr. Baker as moderator.

Dr. Baker also spoke at the evening meeting on "Management of Acute Myocardial Infarction."

**"Your Doctor Speaks"** over FM Station WFJL.—Since the last issue of the Illinois Medical Journal, the following physicians have appeared in transcribed broadcasts in a series "Your Doctor Speaks" over FM Station WFJL:

**Fred W. Hark**, associate professor of orthopedic surgery, University of Illinois College of Medicine, November 26, Bone Growth.

**William H. Wehrmacher**, clinical assistant in medicine, Northwestern University Medical School, December 3, High Blood Pressure.

**Herman F. Meyer**, assistant professor of pediatrics, Northwestern University Medical School, December 10. Reversion to an Ancient Practice—Rooming-In.

**Adrien Ver Bruggen**, clinical professor of neurological surgery, University of Illinois College of Medicine (Rush), December 17, Sciatica.

**"Your Doctor Speaks"** is presented under the auspices of the Educational Committee of the Illinois State Medical Society in cooperation with FM Station WFJL.

**Lectures Arranged Through the Educational Committee of the Illinois State Medical Society:**

**Howard S. Traisman**, Parent Education Discussion Group of the Von Steuben PTA, December 7, on Learning to Understand Children.

**Walter C. Bornemeier**, radio interview on "Nancy Terry Presents", WMAQ, December 12, on Review of Chicago Medicine.

**Felix A. Tornabene**, Aurora, Parents' Club of the Immaculate Conception School in Morris, January 11, on The Parents Part in Preventive Medicine.

**Albertine L. Rea**, Ames Parent-Teacher Association in Riverside, February 9, on How Can a Child's Sense of Security be Developed?

**Alfred Flarsheim**, Schubert PTA, February 16, on Emotional Development of Children.

**Joseph A. Bertucci**, Oak Park, Millard Avenue Junior Woman's Club, February 18, on Childhood Diseases.

**Carl C. Pfeiffer**, Hyde Park Travel Club, February 22, on How Miracle Drugs Are Born.

**Morris T. Friedell**, Chatham Field's Woman's Club, February 26, on Recent Advances in Medicine.

**Lectures Arranged Through the Scientific Service Committee of the Illinois State Medical Society:**

**Harvey White**, Chicago, Kane County Medical Society in St. Charles, December 9, on Congenital Anomalies of the Gastrointestinal Tract in Infants and Children.

**Murray Franklin**, Chicago, Green County Medical Society in Roodhouse, December 10, on Cortisone: A Clinical Application of Its Usefulness.

**Gordon H. Scott**, Chicago, Rock Island Chapter of the Academy of General Practice in Moline, December 15, on The Office Management of Ear, Nose and Throat Conditions from the Standpoint of the General Practitioner.

**Walter W. Dalitsch**, Chicago, joint meeting of the Marion County Medical and Dental Societies in Centralia, December 17, on Medical-Dental Aspects of Diseases of the Oral Cavity.

**Willard O. Thompson**, Chicago, St. Clair County Medical Society in East St. Louis, January 7, on Thyroid Diseases: Classification, Diagnosis and Treatment.

**John L. Keeley**, Chicago, LaSalle County Medical Society in Ottawa, January 14, on The Management of Megacolon.

**Egbert H. Fell**, Chicago, LaSalle County Medical Society in Ottawa, February 11, on Intracardiac Valvular Surgery which would cover indications and contraindications for such procedure and including such problems as mitral, pulmonary and aortic valvular stenosis.

**Richard B. Capps**, Chicago, Whiteside-Lee County Medical Societies in Sterling, February 18, on The Diagnosis and Treatment of Cirrhosis of the Liver.

**Frederick H. Falls**, Chicago, Stock Yards Branch, Chicago Medical Society, February 18, on The Diagnostic Significance and Treatment of Gynecological Bleeding.

**Samuel G. Taylor, III**, Chicago, DeKalb County Medical Society, in Sycamore, February 23, on Adrenalectomy in Cancer.

**William H. Requarth**, Decatur, Montgomery-Macoupin County Medical Societies in Litchfield, on February 23, on Injuries of the Hand and Surgical Treatment.

**"All About Baby"** over **WBKB**.—Since the last issue of the Illinois Medical Journal, the following physicians were scheduled to appear in the telecast **"All About Baby"** which appears daily over **Station WBKB**:

**S. C. Henn**, attending pediatrician, St. Luke's Hospital, December 16.

**Peter J. Cotsirilos**, member pediatrics staff at Garfield Park Hospital, December 23.

**Harold A. Rosenbaum**, member staff at Children's Memorial Hospital, December 30.

**James Wallace**, attending pediatrician at Shriner's Hospital for Crippled Children, January 6.

The physicians appearing on **"All About Baby"** are scheduled by the **Educational Committee of the Illinois State Medical Society**. The telecast is produced by the Herbert Laufman Television Productions and is sponsored by the Libby Foods, Swift Meats and Toni Companies.

## DEATHS

**Edward L. Arensdorf**, Chicago, who graduated at Loyola University School of Medicine in 1929, died December 5, aged 50. He was assistant chief surgeon for the Chicago and Eastern Illinois, and the Chicago and Western Indiana railroads and district surgeon for the Wabash railroad. He was a member of the Illinois State Medical Society.

**William Sherman Baldwin**, East St. Louis, who graduated at Jenner Medical College, Chicago, in 1907, died in St. Mary's Infirmary in St. Louis on August 1, aged 77.

**Lewis T. Baxter**, Elmwood Park, who graduated at the University of Illinois College of Medicine in 1920, died November 12, aged 57. He was a member of the Chicago Society of Industrial Medicine and Surgery and the Illinois State Medical Society.

**John Archibald Brown**, Kankakee, who graduated at McGill University Faculty of Medicine, Montreal, Quebec, in 1893, died December 2, aged 82. He was a past president of the Kankakee County Medical Society and a member of the Illinois State Medical Society.

**Benjamin H. Burgner**, Chicago, who graduated at Chicago College of Medicine and Surgery in 1916, died October 15, aged 75, of pulmonary tuberculosis. He was a member of the Illinois State Medical Society.

**Lee Henry Harlan**, Chicago, who graduated at Illinois Medical College, Chicago, in 1910, died October 20, aged 73, as the result of a fall from a third floor window.

**Paul Hertel**, Chicago, who graduated at Bennett Medical College in 1915, died recently, aged 75.

**Burton L. Hoffman**, Chicago, who graduated at the University of Chicago School of Medicine in 1941, died December 2, aged 37. He was a lieutenant commander in the navy in World War II.

**Mary B. Legat**, Fox River Grove, who graduated at Illinois Medical College, Chicago, in 1908, died October 28, aged 82. She was a member of the Illinois State Medical Society.

**Frederick J. Lesemann**, formerly of Chicago, who graduated at Rush Medical College in 1908, died November 26 in Los Angeles, aged 73. He was a member of the surgical staff of Englewood

Hospital, until his retirement a year ago, and a member of the Illinois State Medical Society.

John Francis Lewis, LaSalle, who graduated at University Medical College of Kansas City, Missouri, in 1905, died October 9, aged 74, of coronary occlusion. He was a member of the Illinois State Medical Society, a past president of the North Central Illinois Medical Association, and affiliated with St. Mary's Hospital in LaSalle and St. Margaret's Hospital in Spring Valley.

Kenneth Oliver Nelson, Chicago, who graduated at the University of Chicago School of Medicine in 1947, died October 24, aged 30, in Evanston Hospital. He served during World War II.

John Patrick O'Connell, Chicago, who graduated at the College of Physicians and Surgeons of Chi-

cago, School of Medicine of the University of Illinois, in 1906, died October 20, aged 69, of acute myocardial infarction. He was a member of the Illinois State Medical Society and for many years chief medical examiner of the Chicago Civil Service Commission.

Harry V. Thomas, Chillicothe, who graduated at the College of Physicians and Surgeons of Chicago, School of Medicine of the University of Illinois, in 1906, died September 19, aged 70, of coronary disease. He was a member of the Illinois State Medical Society, a member of the American Association of Railway Surgeons, and past president of the staff of Proctor Hospital.

Vincent Tornabene, Chicago, who graduated at Chicago College of Physicians and Surgeons in 1909, died November 29, aged 78.

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## SUMMARY OF A DENTAL STUDY

A series of 52 cases of herpetic stomatitis associated with a generalized lymphadenopathy, leading to diagnosis of infectious mononucleosis is presented. In 80 per cent of cases, the oral lesions preceded positive blood smear and agglutination tests. Thirty-seven patients sought dental consultation as their primary complaint. The effectiveness of therapeutic B complex in controlling the lesions in herpetic stomatitis, herpangina, and recurrent aphthous stomatitis is discussed. The presence of herpetic stomatitis in association with generalized lymphadenopathy is, in our opinion, consistent with the early diagnosis of infectious mononucleosis. *Irving G. Nathanson, D.D.S. and George E. Morin, D.D.S., Herpetic Stomatitis. Oral Surg. Nov. 1953.*

## NIGHT CRAMPS

Night cramps may be due to arterial insufficiency, prolonged standing, poor foot posture, flat arches, genu valgus, potassium imbalance (in diabetic), hyponatremia, hypochloremia, nerve root irritation, venous stasis, hypocalcemia, hyperphosphatemia (pregnancy), and other causes. Specific treatment such as aluminum hydroxide for the hyperphosphatemia of pregnancy, elastic bandages for venous insufficiency, etc., is indicated. Symptomatic treatment is satisfactory and consists of diphenhydramine hydrochloride 50 mg. and quinidine sulfate grs. III (grams 0.2) with evening meals and on going to bed. *Travis Winsor, M.D., The Management of Peripheral Arterial Occlusive Disease. Arizona Med., Nov. 1953.*

# Tuberculous Infection in the Light of Tuberculin Matriculation

By Tobias Gedde-Dahl, M.D., *The American Journal of Hygiene*, September, 1952.

(Ed. Note: The decline in the tuberculosis death rate in some sections of the United States has led to a situation in which virtual eradication in these local areas is now a possibility. In this connection the summary of an extended study of the epidemiology of tuberculosis in a rural population in Norway is presented. The material, of which the article cited is but a part, was published in book form in the Norwegian language.)

Tuberculosis control measures may be based on the assumption that early treatment hinders existing or potential sources of infection from spreading the disease, and shortens duration of institutional treatment. If most cases of pulmonary tuberculosis develop soon after infection, then the demonstration of the change from a negative to a positive tuberculin reaction provides the earliest diagnosis.

Tuberculin matriculation was the term applied to tuberculin testing of the whole population, which was then divided into a tuberculin-positive and a tuberculin-negative group. The latter was retested with tuberculin at suitable intervals. The positive group and the converters were kept under radiological observation until the risk of disease was minimal and were retested with tuberculin at long intervals.

When, in 1937, the author began to carry out tuberculin matriculation, several questions arose. Was tuberculin matriculation feasible in Norway? What was likely to be discovered with regard to tuberculous infection, disease and transmission? Can tuberculous infection be controlled? Can the further spread of infection, morbidity and mortality be influenced thereby?

The experiment was made in the medical district of Kinn with a population of about 6,500 persons engaged, for the most part, in fishing and farming. In each school district all inhabited houses were mapped and numbered. All households were listed with the name and occupation of each family member and information concerning the tuberculin reaction, tuber-

culin conversion, illness, contact with tuberculosis and x-ray examinations. Individual health examination cards were filed by families. The cards of persons with notified tuberculous disease and converters were kept in a separate file, the tuberculosis register. The nurses who did most of the work in tuberculin matriculation also had a generalized public health program.

The study proved that it was possible within a limited area to reduce the spread of infection from primary infection tuberculosis, that is, pulmonary tuberculosis developing during the first few years after infection. This is notably the case with tuberculosis in juveniles. However, in a few instances spread of the disease occurred even in the primary phase before diagnosis. In some instances control has been deficient. It has proved impossible to prevent all infections by juvenile sources of infection among newcomers and visitors. Many of these individuals had, presumably, primary infection tuberculosis (hilus cavities in two cases). When tuberculosis control is effected throughout the country it should be possible to protect ourselves against such infections. But spread of the disease continues owing to new outbreaks of old disease, relapses or progressive changes occurring long after the original infection. Progressive disease often follows defective treatment and observation. Spread of infection may also be due to defective cooperation between physicians and the health councils, and lack of continuity in local health activities. Many patients feared relapse and tried to void examination.

In most cases the spread of infection could be avoided by more vigorous treatment and more complete follow-up of older patients with tuberculosis. Yet, however accurately we carry out the health examinations, we cannot achieve complete victory over infection until the public has become better informed. It sometimes happens that an infectious form of primary pulmonary tuberculosis runs such a rapid course that others have been infected before the next scheduled

(Continued on page 48)



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examination. A flare-up of an older infection may also occur rapidly. In many instances the ignorance and asocial attitude of the sources of infection have contributed to the spread of infection. There is a difference between infectious and infecting pulmonary tuberculosis. We consider every person with lung infiltrations and bacilli found through smear of gastric lavage, or with only a suspect cavity, to have "infectious tuberculosis." This estimation, however, gives misleading figures of the frequency of infecting tuberculosis.

Even if we realize how dangerous some infection sources may be, we are impressed by the low infectiousness of pulmonary tuberculosis. This may be a question of intimacy of contact or of virulence and viability, that is, the infecting capacity of the tubercle bacilli from different types of pulmonary tuberculosis. These problems are important in the evaluation of our chances to establish efficient epidemiological control of tuberculosis, which are probably much greater than was formerly believed in Norway.

Tuberculin matriculation is a feasible method in tuberculosis control in small towns and rural areas if public health nurses are available. The development of infection may be followed from an early stage and the spread of the disease traced. Moreover, it gives information for a clearer insight into the epidemiology. The facts permit us to consider tuberculosis as a disease which can be fought by epidemiological means which permit early detection and treatment of primary infections and their infectious sources. The lower the infection rate is in a region, the more important is the epidemiological approach

compared with other mass examination methods. As tuberculosis decreases, it becomes important to combine tuberculin matriculation with general health examinations. This plan leads to decentralization of tuberculosis control and to closer and more permanent supervision of the "healthy" population.

Mass radiography as a screening mechanism, though of importance in cities and in persons past middle age, will not be the basic method in the long run. By repeated tuberculin testing it is possible to uncover fresh primary infections and to focus control efforts on the most important group—recently infected persons. X-ray examination of uninfected persons is thereby avoided.

Another valuable supplement is BCG vaccination of exposed persons. However, in regions with low infection rates, mass vaccination will be scarcely practical. A steadily increasing number of persons has to be vaccinated and protected against a diminishing threat. Most important, mass vaccination deprives us of the power to distinguish between the infected and the uninfected making x-ray examination of all the population necessary. Finally, a cardinal factor in making a correct prognosis of a primary tuberculous infection is the knowledge of the time of onset. This factor cannot be known in a vaccinated population.

Therefore, it is concluded that tuberculin matriculation is the fundamental principle in tuberculosis control of the future in regions or populations with low infection rates. The less frequent the occurrence of tuberculosis, the more selective the method must be.



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## BOOK REVIEWS



**VIRAL AND RICKETTSIAL INFECTIONS OF MAN.** Ed. by Thomas M. Rivers, M.D., Director of Hospital, Rockefeller Institute for Medical Research, with 30 collaborators. Second Ed., 719 pages, 90 illustrations, including 7 color plates: Lippincott, Philadelphia, 7.50. 1952.

The second edition of this book bears out the promise of the first edition, and is a fit companion in every way to Rivers' *Bacterial and Mycotic Infections of Man*, published by the same company.

The first 8 chapters cover general aspects of viral and rickettsial infections, including their physical and chemical properties, and serological reactions. Hemagglutination by viruses, an interesting and recently much studied phenomenon, is discussed in a new chapter. Technics of cultivation of viruses in the chick embryo and in tissue cultures are thoroughly discussed, as is the epidemiology of viral diseases. A new chapter is devoted to the occurrence of interference between animal viruses, a phenomenon which may in the future be of great practical significance. Clinical and laboratory data of importance in diagnosis have been collected in a single chapter, in an effort to integrate this complicated subject for the benefit of student and practitioner. In the remaining two-thirds of the book, bacteriophage, specific viral diseases,

and rickettsial diseases are discussed individually. The new edition includes information on human diseases caused by the recently identified Coxsackie virus, and most of the material on other subjects has been edited or revised. Viral and rickettsial have become increasingly important as the antibiotics and public health measures have become more effective, so that smallpox, tuberculosis, plague and syphilis are no longer the important causes of death they were in the past. In spite of this increasing importance of viral diseases, there has been a lack of easily accessible information about these diseases. The present volume is an attempt to fill this need. It has been written by a distinguished group of collaborators each of whom is an expert in his field. In spite of the number of authors, there is relative uniformity of viewpoint about most of the diseases discussed, partly because ideas have now become somewhat stabilized in this field, and partly through the efforts of the editor.

The book contains much valuable information, well organized for student or practitioner. Its publication has been aided by a grant from the National Foundation for Infantile Paralysis, which accounts for the relatively low cost. J. C. S.

**MANIC-DEPRESSIVE DISEASE, CLINICAL AND PSYCHIATRIC SIGNIFICANCE,** by John D. Campbell,

(Continued on page 56)

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Herrold, R. D.: South. Clin. North America 30:61, 1950.

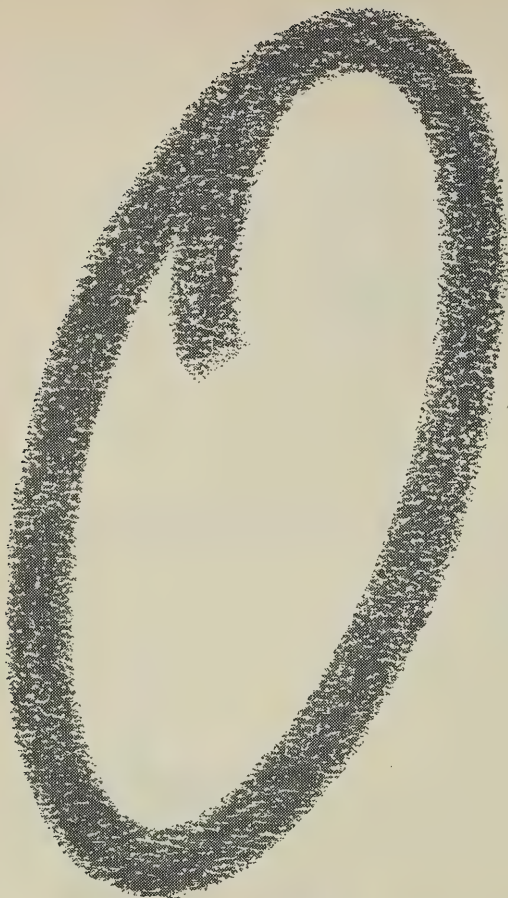
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## **BOOK REVIEWS (Continued)**

M. D. 403 pages. J. B. Lippincott Company, Philadelphia, London and Montreal. 1953. Price \$6.75.

Dr. Campbell offers a very readable book of some 400 pages on a subject which is important to the general practitioner as well as the psychiatrist.

There are numerous references to other writers, but most of the views expressed are based upon 522 cases studied by the author.

A history of the concepts of the disorder and a description of the cycloid personality, the latter a basic factor in the development of the disease, are followed by a delineation of the symptoms. Considerable attention is given to dysfunction of the autonomic system and the possibility of a disturbance in the hypothalamus, a concept which has aroused interest in a number of authorities. The autonomic disturbances, "emotional disturbances", and "mental symptoms" form the triad of manic-depressive manifestations according to the author.

Dr. Campbell performs a distinct service to the profession in calling attention to the mild manic-depressive conditions which, especially when linked with autonomic dysfunctions, simulate nonpsychiatric disturbances. He states many of these do not need hospital treatment.

The chapter on social maladjustments in manic-depressive psychosis includes various difficulties which may arise as a result of the underlying disorder. One of these may easily be interpreted as the primary condition, leading to misplaced effort to correct the trouble. One example cited by the author is an attempt to remedy alcoholic excesses where these are merely secondary to manic or depressive changes. Dr. Campbell states; "There is more specific therapy for manic-depressive disease than there is for chronic alcoholism per se."

A chapter is devoted to the subject of prevention and the treatment of the milder attacks. The first step is proper diagnosis in which the recognition of a previous cyclothymic make-up is important. Explanation of somatic symptoms as far as these are merely the result of autonomic dysfunction, removal of precipitating or aggravating environmental factors, combating unreasonable conscientiousness, psychotherapy, (the

author does not believe psychoanalysis is indicated in these conditions), advice to family and friends, rest and relaxation, occupational therapy and reading are other steps discussed at length.

Where the foregoing efforts do not succeed, Dr. Campbell advocates shock treatment and he offers many valuable suggestions and comments for this type of therapy which has been quite generally accepted by psychiatrists in recent years. He also gives a brief but illuminating review of the efforts to relieve some of our psychiatric patients by means of psychosurgery. S. N. C.

**MEDICAL SCHOOLS IN THE UNITED STATES AT MID-CENTURY.** John E. Deitrick, M.D. and Robert C. Berson, M.D. McGraw-Hill Book Company, New York, 1953 (350 pages including index) Price: \$4.50.

This volume is the report of the Survey of Medical Education carried out under joint sponsorship of the American Medical Association and the Association of American Medical Colleges and some financial assistance from the W. K. Kellogg Foundation for the review of graduate and post-graduate medical education. Forty-one medical schools were visited by the survey team.

The material is presented in five major sections: (1) The function of a medical school in education, research and service; (2) the finances of the medical school; (3) the medical school in operation (concerning administration, hospital relations, departmental structure, faculty, etc.); (4) the curriculum and teaching methods; (5) advanced education and training. Chapter 7 is "A Summing Up".

Although a reader might expect much detail and statistical data in such a report, this volume is easy and rapidly read. Everyone experienced in medicine will find in this volume a mirror reflecting his own experience. At the end of each chapter are "conclusions" and "recommendations". These are specific. For example, at the end of the chapter on "The Medical School in Operation" one recommendation is "Medical Schools should be completely clear, as regards their activities, between those justified as con-

(Continued on page 60)



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## BOOK REVIEWS (Continued)

tributing to medical education and those which are medical service".

The question "What is a medical school and what are its responsibilities" is presented in several ways. Financial problems cannot logically be met until the answer is clear.

The volume presents everywhere the administrative problems in medical schools, especially those with "hospital centers" and states the need for more money for administration.

The emphasis in the volume is on the need of wisdom in planning the use of the educational resources in producing young physicians, stimulating their "curiosity, initiative and freedom", allowing each student "responsibility to the limit of his capacity" while allowing association with men of the highest ideals of practice and ethics. "The vision of greatness must be preserved" and not lost in "a welter of services, research, training welfare functions".

The report by Doctors Deitrick and Berson is

an accomplishment of great value, to be read by most medical teachers, all administrators and many less directly involved, for example fathers whose sons may one day become physicians.

F. K. H.

## BOOKS RECEIVED

The following books have been received for reviewing, and are herewith acknowledged. This listing should be considered as a sufficient return for the courtesy of the sender. Books that appear to be of unusual interest will be reviewed as space permits each month. Readers desiring additional information relative to books listed, may write the Editor who will gladly furnish same promptly.

**DISEASES OF WOMEN.** By ten teachers. Under the direction of Frederick W. Roques, M.D., M. Chir., F.R.C.S., F.R.C.O.G. Edited by Frederick W. Roques, John Beattie, Joseph Wrigley. Ninth edition. Edward Arnold & Co., London. The Williams & Wilkins Company, Baltimore 2, Maryland. \$6.50.

**THE OXFORD MEDICINE.** By various authors. Volume VIII. Edited by Henry A. Christian, A.M., M.D., LL.D., Sc.D. (Hon.), M.A.C.P. Hon. F.R.C.P. (Can.), D.S.M. (A.M.A.) Hersey Professor of the

(Continued on page 62)



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## BOOKS RECEIVED (Continued)

Theory and Practice of Physics, Emeritus, Harvard University, Sometime Clinical Professor of Medicine, Tufts College Medical School, Sometime Visiting Physician, Beth Israel Hospital, Physician-in-Chief, Emeritus, Peter Bent Brigham Hospital, Boston, Mass. Oxford University Press, 114 Fifth Avenue, New York 11, New York. \$25.00.

PRACTICAL METHODS IN BIOCHEMISTRY. By Frederick C. Koch, Late Frank P. Hixon Distinguished Service Professor Emeritus of Biochemistry, University of Chicago. Late Director of Biochemical Research, Armour & Co., Chicago and Martin E. Hanke, Associate Professor of Biochemistry, University of Chicago. Sixth edition. The Williams & Wilkins Company, Baltimore, 1953. \$5.00.

HANDBOOK OF PRACTICAL BACTERIOLOGY. A Guide to Bacteriological Laboratory Work. By T. J. Mackie, C.B.E., M.D., LL.D., D.P.H. and J. E. McCartney, M.D. (Edin. and Adelaide.) D. Sc. (Edin.). Ninth Edition. E. & S., Livingstone LTD. Edinburgh and London. The Williams & Wilkins Company, Baltimore 2, Maryland.

WONDERS OF MODERN MEDICINE. By Steven M. Spencer. Foreword by George F. Lull, M.D., Secretary and General Manager, American Medical Association.

McGraw-Hill Book Co., Inc., New York, Toronto, London. \$4.00.

REVIEW OF PHYSIOLOGICAL CHEMISTRY. By Harold A. Harper, Ph.D., Professor of Biochemistry, University of San Francisco, Lecturer in Surgery, University of California School of Medicine, San Francisco, Biochemist Consultant to Metabolic Research Facility, U. S. Naval Hospital, Oakland Biochemist Consultant to St. Mary's Hospital, San Francisco. Fourth edition. Lange Medical Publications, University Medical Publishers, Los Altos, California \$4.00.

MENTAL HEALTH IMPLICATIONS IN CIVILIAN EMERGENCIES. Report of Subcommittee on Civil Defense, Community Services Committee. National Advisory Mental Health Council, May 1953. U. S. Department of Health, Education, and Welfare, Public Health Service, National Institutes of Health, National Institute of Mental Health. Copies available from the Superintendent of Documents, U. S. Government Printing Office, Washington 25, D. C. 15c.

ION EXCHANGE RESINS IN MEDICINE AND BIOLOGICAL RESEARCH. ANNALS OF THE NEW YORK ACADEMY OF SCIENCES. Volume 57. Article 3. Pages 61-324. November 11, 1953. Editor, Roy Waldo Miner. Conference Chairmen; H. Sobotka and H. P. Gregor. Consulting Editor: Harry Sobotka. 264 pages, illustrated, \$4.50.

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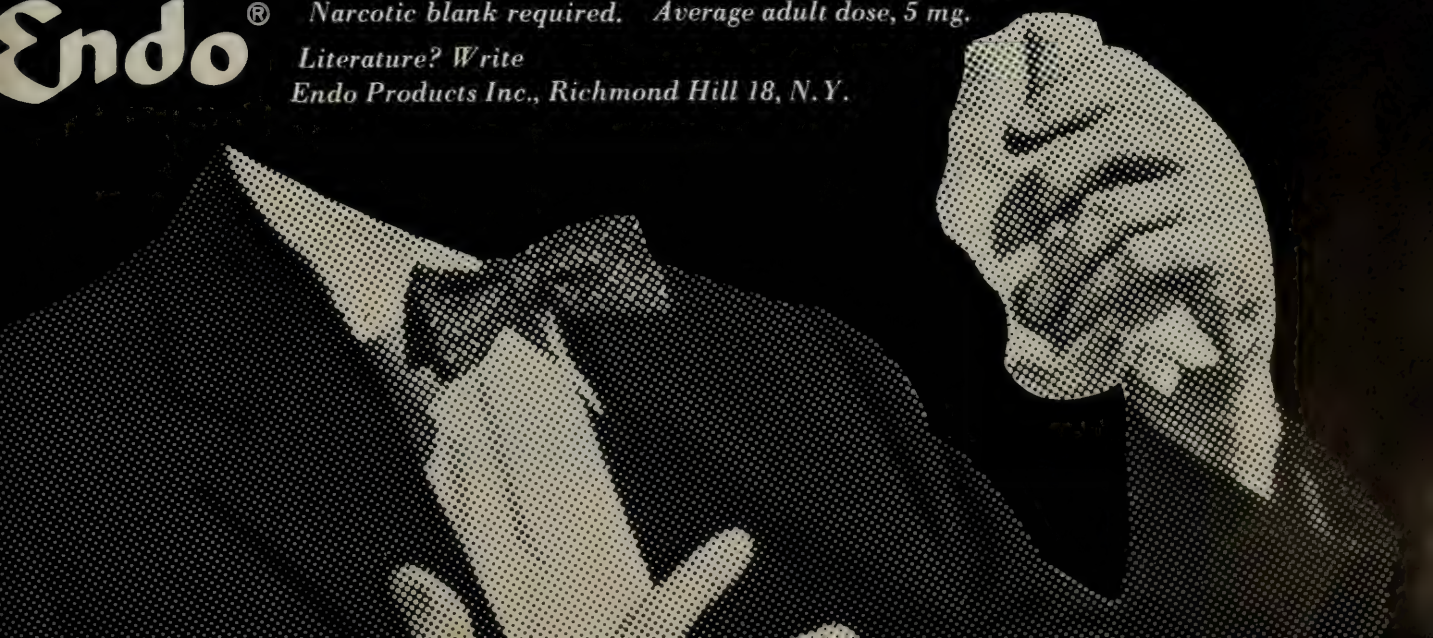
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## WHAT IS "RENAL FAILURE"?

Because the kidney has an effluent which we can see with the naked eye, we tend to think of it as a faucet, that is, something which is either on or off. This has been preserved in our thinking by placing the emphasis on the quantity of effluent rather than its qualities in relation to the body economy. Thus the term "anuric patient" comes easily to the tongue even though completely anuric persons rarely are seen, and the statement "this man is suffering from oliguria" is commonplace even though it has at most an indirect and limited clinical significance. Our thinking would be improved if we compared the kidney with the heart, for example. We say a man has cardiac insufficiency or failure after weighing his work load against his cardiac output. If we cannot increase the latter, we decrease the former and a cardiac-insufficient laborer becomes a cardiac-sufficient hemstitcher. The kidney differs only in the complexity of its function and in the fact that its output is important for its qualities rather than its volume. Thus the recent clinical terminology for renal failure

has emphasized the physiologic rather than the morphologic approach to this subject, and such terms as "renal failure," "renal insufficiency" and "the ischemic episode" have replaced "anoxic nephrosis," "lower nephron nephrosis" and other terms which are more pathologically than physiologically oriented. *George L. Schreiner, M. D., The Treatment of Acute Renal Insufficiency. Medical Annals of the District of Columbia, Oct., 1953.*

There is a "sensitive" period in the effective treatment of tuberculosis which applies not only to the tubercle bacillus, when it is most vulnerable to attack, but also to the patient when he is most receptive of advice. That period is when the disease is first discovered. *Eli H. Rubin, M.D., N.Y. S. J. of Med., June 15, 1953.*

In tuberculosis a realistic acceptance of the illness is a prime essential if medical treatment is to be effective. The patient must not only allow medical procedures to be instituted, but must participate actively in the carrying out of the medical recommendations. *Minna Field, Patients Are People, Columbia University Press, 1953.*



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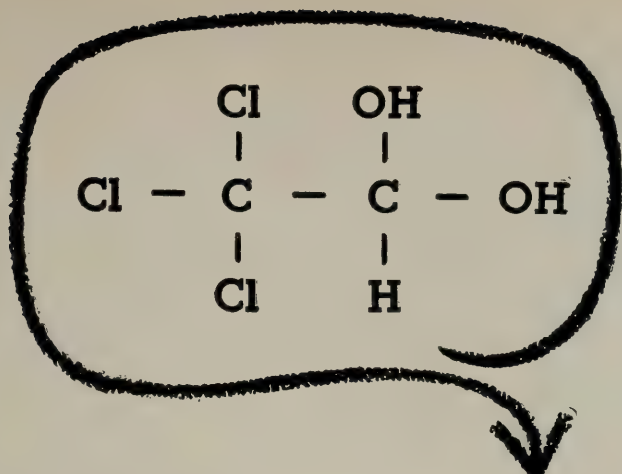
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1. Hyman, H. T.: An Integrated Practice of Medicine (1950)
2. Rehluss, M. R. et al: A Course in Practical Therapeutics (1948)
3. Goodman, L., and Gilman, A.: The Pharmacological Basis of Therapeutics (1941), 22nd printing, 1951.
4. Soliman, T.: A Manual of Pharmacology, 7th ed. (1948), and Useful Drugs, 14th ed. (1947)

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$P^{32}$  may be given intravenously or orally. If given by mouth it should follow an overnight twelve-hour fast with no food for three hours after the dose is given. Repeat doses may be given two to three months later, depending upon the blood count.

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**Dangers:** Since  $P^{32}$  is concentrated by young and rapidly growing cells, the danger of sterility in young people must be kept in mind because of concentration of  $P^{32}$  in the gonads. For this reason the question of its administration to children should be carefully weighed. *Harry Statland, M.D., Sidney Rubin, M.D., Leonard Walker, Ph.D., The Application of Radioisotopes to Clinical Practice. Missouri Med., Nov., 1953.*

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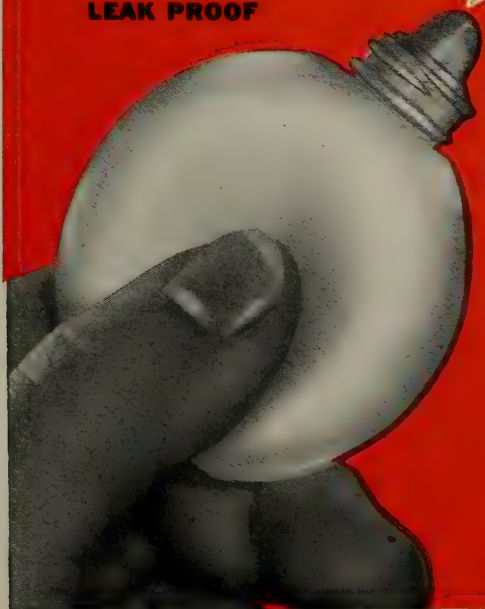
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## THE INDUSTRIAL INJURY

Many of you realize that the man who sustains an injury in industry usually requires a longer healing period than does the individual having a similar injury at home. Factors such as feeling of job insecurity, depression from breaking perfect safety records, economic instability, etc., are reasons for this delay in recovery. Consequently in severe cases it is necessary to begin rehabilitative work immediately. In the early stages this means not only that the patient should have the best hospitalization and the best specialty care, but also that he be convinced that these things are in effect. He must be treated optimistically. He should be told of his injury, but not in a manner that may be frightening or arouse suspicion. He must be treated as a "whole man" while treating him separately. The time for dehospitalization must be elected wisely as well as the time of return to work. It is needless to say that we have all been guilty of mishandling this phase of an injured man's rehabilitation. However, as long as we develop our opinions on these matters scientifically, logically and sincerely, and not by "guestimations" the chances of erring will be held to a minimum. In some instances the injured will rehabilitate more quickly when he is permitted to return to some type of restricted work. *Kieffer Davis, M. D., Relation Of The Private Physician To Industry. J. Oklahoma M.A., Oct., 1953.*

Mass community (chest X-ray) surveys have been most valuable, and from them we have learned to pinpoint our targets. We started out with the idea that all one had to do was to seek out the cases through mass surveys and all TB eradication would be added unto us, but it turned out to be more complicated than that. Actually all the mass surveys provide is a cross-section of the active disease on one day of the year or one day in three years—the average interval between surveys. A good deal of tuberculosis can develop in the interval and it is important to have facilities to find it. The other point is that prompt follow-up is essential. Too many people who conduct surveys think the important point is numbers rather than a prompt follow-up of those abnormal films. Proper selection and timing of such surveys, with adequate follow-up through coordination with regional clinics, will be the watchword of the next decade. *C. J. Wherrett, M.D., Canadian J. of Pub. Health, May, 1953.*

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### MAMA TROUBLE

The key to good doctor-parent relations lies largely in an understanding attitude on the part of the physician. However, I must admit that at times the keeping of an understanding heart would tax the moral strength of a fully inspired saint. Exasperating instances in any doctor's practice would fill a book full of incidences with a familiar "that's-just-what-happened-to-me" ring. There are the calls to the physician instead of the dentist in the wee hours because the latter was undoubtedly asleep and, says Mama, "I just hated to get him up." Have others had mother explain that she was afraid to put her baby on boiled water for fear it would scald his mouth? At such times as these, professional equanimity comes hard. It is simply a matter of maintaining tranquillity and suppressing any indignant outbursts with a self-reminder that you are seeing things through the calm eyes of a trained physician rather than the frightened eyes of a medically untrained parent. So the next time Mama goes into a long explanation of her baby's gastro-intestinal upset with lengthy dwelling upon how he vomits up his milk "all

curdled and sour," humble yourself with the reflection that it took a hole in Alexis St. Martin's stomach and the brains in William Beaumont's head to help educate you along these same lines! *Keith Hammond, M.D., Doctor-Parent Relations. J. Ind. M.A. August, 1953.*

The antituberculosis movement synthesized in one single crusade the efforts of sociologists, humanitarians, and hygienists to improve the fate of the destitute by social reforms; to strengthen the human body by advocating a healthy way of life; to control infection by tracking and destroying the tubercle bacilli. *Rene J. Dubos, Ph.D., Am. Rev. Tuberc., July, 1953.*

Many cases of pulmonary tuberculosis are either disregarded by the patient or are symptomatically latent, and even after pathological examination it is not always possible to say whether we are dealing with reinfection or reactivation. *George Blumer, M.D., Conn. State Med. J., May, 1952.*

We just heard about the drunk who fell out of a six story window and landed in the street without apparent harm. A crowd gathered around him and a cop rushed up and said, "What happened?"

"I don't know," said the drunk rising and brushing himself off. "I just got here myself."

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We have reported on 10 patients in whom serious untoward gastrointestinal manifestations appeared during or after administration of cortisone or corticotropin. Death occurred in one patient who had chronic ulcerative colitis and in whom perforation of the cecum and peritonitis developed. Perforation of the bowel and peritonitis occurred in two of four patients who had regional enteritis; an enterocutaneous fistula was present in one of these as a result of the perforation. Perforation of an intraabdominal abscess occurred in a third patient who had this disease. The fourth patient who had extensive regional enteritis also had ulcerative esophagitis that either developed during or was aggravated by administration of corticotropin. Complications of peptic ulcer occurred in two patients who had extensive hypercortisonism. One of these patients had massive hemorrhage and ultimately died as the result of adrenal insufficiency after surgical removal of the ulcer. The second patient experienced reactivation of an ulcer and massive

hemorrhage; subsequent resection was required. A gastric ulcer that was intractable to medical management appeared in a third patient who had hypercortisonism. Ulcerative rectal lesions developed in three patients; two of them had hypercortisonism, one of whom also had a large intractable gastric ulcer, as just mentioned. The third patient in this group had proctoscopic findings and clinical symptoms compatible with chronic ulcerative colitis that developed while he was receiving cortisone for treatment of rheumatoid arthritis.

Although it is possible that the occurrence of gastrointestinal complications in patients receiving cortisone or corticotropin is entirely by chance, the evidence from our study and from reports in the literature strongly suggests that administration of these hormones may be a causative factor. That it is not the only factor is apparent from the large number of patients who receive these agents and who do not experience any such complications. Evidence now available appears to justify exercise of cau-

*(Continued on page 78)*

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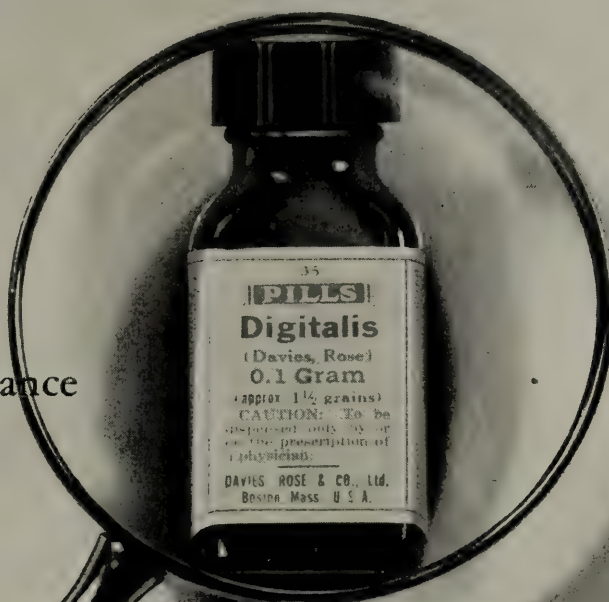
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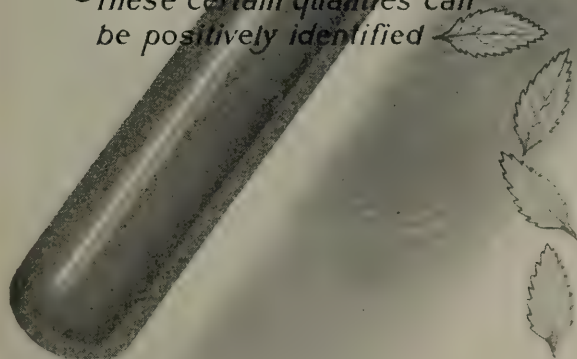
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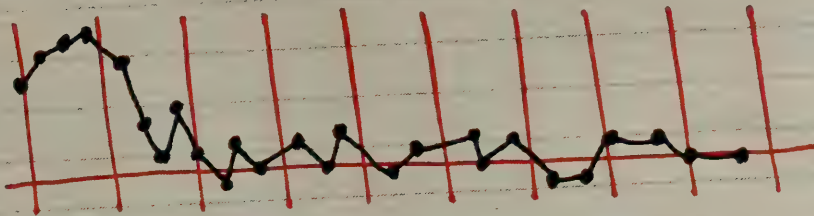
tion in the administration of these materials and suggests the importance of close supervision of patients receiving them. The role of cortisone and corticotropin in the production of gastrointestinal complications can become more clearly defined only by means of carefully conducted clinical and statistical studies of patients receiving these hormonal agents. *William G. Sauer, M.D., et al. Serious Untoward Gastrointestinal Manifestations Possibly Related to Administration of Cortisone and Corticotropin. Proc. Staff Meet., Mayo Clin., Nov. 18, 1953.*

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In New York State exclusive of New York City the percentage of minimal cases reported in 1952 (33 per cent) is the lowest since 1942, while that of far advanced (27 per cent) is the highest since 1940. Less than five per cent of reports of these pulmonary cases did not indicate the stage of disease. Over half of these cases were reported by county and city tuberculosis hospitals and clinics. N.Y.S. Dept. of Health, Div. of TB Control, 1952 Annual Report.

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1. Knight, V.: New York State J. Med. 50:2173 (Sept. 15) 1950.

2. Potterfield, T. G., and Starkweather, G. A.: J. Philadelphia Gen. Hosp. 2:6 (Jan.) 1951.

3. Swift, P. N.: Proc. Roy. Soc. Med. 44:1066 (Dec.) 1951.

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Harold M. Camp, EDITOR.

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Vol. 105, No. 2

February, 1954

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## The Treatment of Certain Common Forms of Headache Confused with Sinus Headache

Henry L. Williams, M.D.  
Rochester, Minnesota

It has been estimated that 25 per cent of patients presenting themselves to a physician have some form of headache as a chief complaint.

Headache only rarely indicates a serious condition inside the skull, but because of this possibility and the fact that the different varieties of headache often have not been clearly distinguished, many physicians have avoided attempts to relieve this complaint if more is required than analgesic medication. This attitude is unfortunate because differentiation of the various types of headache is usually easy, and symptomatic relief can often be obtained by simple methods readily applicable in the office.

Headaches, like other symptom-complexes, usually fall into readily recognizable clinical patterns or pictures. These can be recognized by a carefully taken history and physical examination. These two steps in diagnosis, especially the latter of the two, unfortunately sometimes are neglected.

A prerequisite for a clinically useful history is a clear understanding of the meaning of terms.

---

Read at the meeting of the Illinois State Medical Society, Chicago, Illinois, May 13 to 15, 1952.

From the Section of Otolaryngology and Rhinology, Mayo Clinic, Rochester, Minn.

By the word, headache, patients often try to describe two separate sensations. The first is a sense of constriction, weight, fullness or sensation of expansion in the head. The second is pain felt to be within the head. After differentiation between these two types of sensation is obtained by careful questioning, it is most important to remember that pain itself, as originally pointed out by Lewis<sup>1</sup>, is of two types.

The first type, superficial pain, is of a bright burning quality, whatever the stimulus that produces it. Superficial pain is associated with increased activity, a more rapid pulse rate and heightened blood pressure. It is characteristic of irritation of skin and superficial layers of the mucous membranes and of superficial fibrous and elastic tissues such as joint capsules and tendons of muscles. Most important of all, superficial pain exactly locates the site of irritation.

The second type of pain, deep pain, has an aching persistent character, is associated with quietude and withdrawal, a drop in pulse rate and blood pressure and is often accompanied by nausea, for which reason it is frequently termed "sickening." It is associated with irritation of deeper structures such as muscle and blood ves-

sels. Most important of all it does not exactly locate the site of irritation, but tends to be felt at a distance from the area stimulated in a distribution, not of the cutaneous sensory nerves, but rather along myotomes and the distribution of blood vessels. For this reason it is sometimes termed "referred pain."

Appreciation of the existence of these two types of pain is important in differentiating different types of headache.

*The Clinical Pattern of Pressure Sensations.* — The tight band around the head, not severe enough to be painful, is a typical sensation complained of by tense individuals, and is produced by a mild involuntary increase in tension of the temporal muscles. A sympathetic attitude toward the complaint, practical advice, teaching mechanical methods of relaxation, the use of heat and massage to the affected muscles of the head and neck generally together with relaxing hydrotherapy, will often give relief. It has been stated that psychiatric care has been helpful in obtaining relief for this group of individuals.

A complaint of a feeling of expansion in the head is common in individuals who have faulty water metabolism and tend to retain sodium and interstitial fluid. This appears to be due to an inherited tendency accentuated by incorrect diet, excessive fatigue and exposure to atmospheric changes. This complaint can often be relieved by correction of the daily routine of living, the eating habits, and occasionally by giving vitamins. Fresh air enthusiasts who insist on exposing themselves, especially at night, to the rigors and inclemencies of the weather are especially apt to complain of this sensation.

*The Clinical Pattern of the Neuralgias.* — The causes of the major neuralgias, such as tic douloureux, glossopharyngeal neuralgia and occipital neuralgia, are imperfectly understood. It has been pointed out, however, that epithelial tissues are relatively deficient in blood supply. The hypothesis has been presented that the sensory ganglia are for this reason prone to relative ischemia which produces irritation and the neuralgic pain. This pain is notable in its lightning-like character, its distribution along divisions of the sensory nerves, the demonstration of trigger areas and the temporary relief obtained by the anesthetization of such trigger areas. Hilger<sup>2,3</sup> has stated that he has been able to secure relief by the intravenous use of 0.02 per

cent solution of procaine hydrochloride, an efficient vasodilator, as well as by solutions of histamine, nicotinic acid, monoethanolamine nicotinate and other vasodilators given both by mouth and by vein. Alcohol injection or division of the sensory root of the affected ganglion is often found necessary, however.

*Headache Associated With Superficial Pain.* — True headaches are made up of deep or superficial pain felt to be within the head. Superficial pain is rarely seen in acute disease of the nose and paranasal sinuses, except in the early stages. As soon as the inflammation extends to the vessels of the submucosa, deep referred pain is produced. Superficial pain, however, may be associated with fibrositis both of the primary and secondary type. The fibrous attachments of muscles about the head may be affected and headache may be produced.

Although the cause is unknown, fibrositis is common. It is the source of pain in many of the tendons and joint capsules that is frequently referred to as rheumatic. The sensation produced in the affected individual is frequently described as being like the thrust of a hot iron rod. Primary fibrositis in the region of the head and neck is rather rare, but fibrositis secondary to arthritic changes in the cervical portion of the spinal column is not uncommon and may produce a nuchal headache.

The subjective grating noises which certain individuals observe on flexion of the neck and rotation of the head are apparently associated with fibrositis.

*The Clinical Pattern of Fibrositis of the Neck and Head.* — The clinical pattern is as follows: 1. The pain is of a superficial type and does not tend to be referred. 2. Stiffening from disuse or lack of motion and relief by mild exercise are characteristic of fibrositis. 3. The condition is usually bilateral and most commonly occurs in the muscular attachments in the nuchal line. Moderate tenderness to pressure may be elicited diffusely in this region. 4. The symptoms may be "dicrotic." That is, mild exercise may relieve, but if such exertions are carried to an extreme an accentuated pain will return. 5. In marked contrast to myalgia (see later), salicylates give prompt and marked relief whereas vasodilators give only slight relief.

The most characteristic form of fibrositic

headache is seen in individuals who have fibrositis of the nuchal region. In such individuals, unusually sound sleep, such as follows the taking of sedatives or extreme fatigue, may be followed by waking in the early morning hours by a severe burning nuchal pain and by an intense frontal headache. The frontal headache, referred pain, is the result of reflex spasm of the cervical muscles set up by the fibrositic pain. On waking, movement of the head in various directions will cause the pain gradually to disappear. Massage will hasten relief.

The most effective treatment, however, for an individual who is subject to frequent headaches of this type, is the use of salicylates at bedtime. While maximal relief of pain can be secured by aspirin, grains 10 (0.65 gm.), such relief is dissipated in one to two hours. Longer relief can be obtained by larger doses which will increase the blood levels. Aspirin, grains 20 to 30 (1.3 to 2 gm.) taken at bedtime, are often sufficient to give relief for the entire night, but some individuals find it necessary to wake themselves after four or five hours for a second dose. Since aspirin is irritating to the gastric mucosa, I have found that following the aspirin by aluminum hydroxide and magnesium trisilicate (2 to 4 tablets of gelusil well chewed) will best prevent symptoms of gastric irritation.

#### *Headaches Associated With Deep Referred Pain.*

— This type of pain, rising as it does from muscle and blood vessels, is probably the most common form of pain in the head. It can be conveniently subdivided into the pain rising from muscle tissues, and that rising from vascular tissues.

*Sinus Headache.* — Sinusitis has long been considered a painful condition, and indeed in acute sinusitis there seems occasionally some basis for this contention. In acute sinusitis, if the pressure produced in the sinuses is sufficiently great to cause pressure in the vessels of the submucosa, a referred headache will be produced. However, in most instances of acute sinusitis it will be found that by relieving the congestion and contacts in the nasal chambers themselves, the headache associated with acute sinusitis will usually be completely relieved. Therefore, the headaches associated with sinusitis are usually nasal contact headaches and may be relieved by measures directed toward relieving the engorgement of the nasal mucosa.

The simplest remedy, and one often giving great relief, is an upright position in bed. The importance of this measure in the treatment of upper respiratory infections is frequently overlooked. Nasal congestion is produced by cold air striking not only the nasal mucosa but also exposed skin surfaces. Therefore, the patient should stay indoors and be protected from drafts. Ventilation, if felt necessary, should be secured from an adjoining room. A high relative humidity should be maintained.

Vasoconstricting nose drops should be strictly avoided as they purchase a meager and short-lived relief at the expense of a prolonged and refractory secondary congestion.

After the hyperirritability of the acute stage has subsided, decongestion of the nasal mucosa can best be secured by some mild irritant, such as the Dowling pack. This results in a progressive decongestion on succeeding days without the secondary rebound phenomenon produced by the vasoconstrictors.

Exceptions.—In spite of experimental evidence to the contrary, a severe headache produced by pressure within a sinus will occasionally be found. This may be produced by the pressure of pus in chronic sinusitis and by osteoma or a mucocele. When the usual simple measures fail to relieve a headache associated with an acute or chronic upper respiratory infection, a roentgenogram of the sinuses is indicated. This may reveal one of the conditions just mentioned. In these exceptional cases suitably directed surgical treatment will give permanent relief to headache. There is, therefore, no clinical pattern for a "sinus headache." The elaborate patterns of diurnal variation ascribed to involvement of various sinuses will be found to depend on activity, tension and nasal congestion, rather than on sinusitis, which usually is a painless disorder.

*Headaches Arising From Muscular Structures About the Head.* — *Muscle Tension Headache.* — A chronic state of tension in the postural muscles of the head and neck will produce a deep referred type of pain. Muscle tension headache is characteristically bilateral.

A frequent cause of such headache is anxiety. In this condition the muscles of the body, especially those of the shoulder girdle and neck, are maintained in a state of hypertonicity and after a time will produce an occipital headache

referred upward and forward toward the vertex. Since hypertonicity of the temporal muscles is usually additionally present and the occipitofrontalis muscle is also frequently in hypertonus, the "hat band headache," so frequently termed the "typical neurasthenic headache," may be produced. Occasionally a throbbing vascular type of pain may be associated with the steady aching pain. This may be due to reflex vasodilatation of the extracranial arteries. Variation in the degree of severity of this type of headache depends on the emotional state of the patient. Often occupations that distract the patient from an adjustment problem will give relief to the headache, while rest in bed, if accompanied by sleeplessness and useless concentration on the problem, frequently will result in accentuation of the pain.

During the various states of fatigue, exhaustion and nervousness, physicians commonly prescribe rest and relaxation without instructing the patient in a technic by which such relaxation may be obtained. For progressive relaxation Jacobson<sup>4</sup> has described a technic which is frequently effective. Physical therapy, especially hydrotherapy and light generalized massage, will often give marked relaxation. Patients frequently volunteer the information that marked relief has been obtained from a facial massage.

Simons, Day, Goodell and Wolff<sup>5</sup> have shown that sustained pain anywhere in the head will produce a chronic state of tension in the muscles of the head and neck which can be a secondary source of deep referred pain in the forehead and temples.

**Fatigue Headache.**—The daily work of some individuals tends to force them to hold the head in a particular position for long intervals of time. Muscles are not designed for continuous tonic contraction. The average individual frequently changes the position of the head and transfers the strain of holding the head erect from one muscle group to another and prevents the accumulation of substances capable of irritating the nerve endings subserving pain. In fatigue headache there is a tendency for the head to be maintained in one position.

This type of headache frequently occurs among truck drivers, typists, operators of business machines and the like who may hold the head in a more or less rigid position throughout the day's

work. This headache frequently can be relieved by an explanation of its cause, pauses at intervals for muscular relaxation and local application of heat and massage.

A closely related group of headache sufferers has been described by Roberts.<sup>6</sup> This group consists particularly of younger individuals with insufficient rest and inadequate nutrition who try to combine active evening social activity with a daytime business or occupation. Such persons frequently exhibit an exacerbation of head pain in the late morning, relieved by lunch and another exacerbation in the late afternoon relieved by the evening meal. Roberts' paper deserves careful study by all physicians because of the sound common-sense directions which it contains on the handling of this type of patient.

**Myalgia of the Head.** — One type of headache which arises from muscle is rarely diagnosed. This is most unfortunate since it is one of the most common forms of headache, and diagnosis is simple and relief by treatment is easy to obtain. The headache is caused by an allergic reaction in muscle or myalgia.

I<sup>7</sup> have pointed out that the fundamental reaction of allergy, whether of an antigen-antibody or a physical type is a reaction of the peripheral arterial bed. In certain areas arteriolar constriction with capillary and venular dilatation and atony may lead to local tissue anoxia, increased capillary permeability, increase in interstitial fluid and the release of toxic substances such as histamine, heparin, and the like depending on the type of cell injured. There is evidence that such reactions tend to occur in individuals who have a tendency toward dysfunction of the autonomic nerves, specifically cholinergic hyperactivity.

Areas of hyperreactivity of the cholinergic nerves are more apt to appear in the head and cervical region because these are the areas which show the emotional reactions transmitted by the autonomic nerves, that is, the site of the flushing and paling to emotional perturbations. This seems to result in a special autonomic instability in these regions.

The myalgias nearly always appear as the result of the action of physical or emotional stimuli, although some physicians wish to incriminate food allergy in certain instances. A demonstrable antigen-antibody mechanism as-

sociated with myalgia is rare. Myalgia may be initiated by an acute or sometimes even chronic infection since it has been shown that physical sensitization takes place more readily in the presence of infection.

Myalgia of the head and neck is characterized by the recurring presence of isolated firm and tender areas in the bodies of certain muscles of the head and neck. It is characteristic for these tender regions to recur in the same locations. In attacks of myalgia these regions become increasingly tender and produce pain referred to a distance in a distribution not that of the cutaneous nerves but rather of myotomes. The pain is of the deep type, rises slowly to a crisis and slowly subsides.

As is usual with allergic headaches these headaches tend to be unilateral but in rare instances they may be bilateral. When this is the case, however, the pain tends to be more severe and the signs more definite on one side or the other.

Certain definite muscles or muscle groups tend to be involved in myalgia of the head and pharynx. The muscles involved are the upper border of the trapezius, the splenius capitis, the upper third of the sternocleidomastoid, the temporal, the stylohyoid and anterior belly of the digastric, the crico-arytenoideus posticus, the mylohyoid, the insertion of the palato-glossus into the tongue (the rest of the musculature of the tongue remaining free of tenderness) and the superior constrictor of the pharynx. The importance of palpation of the structures of the head and pharynx in the diagnosis of myalgia was pointed out by Mithoefer<sup>8</sup>, one of the first in this country to stress the importance of this condition.

I<sup>9</sup> have pointed out the association of myalgia with vasodilating (vaso-atonic) pain, endolymphatic hydrops and vasomotor rhinitis and the fact that together they form the syndrome of physical allergy of the head.

Patients who are subject to myalgia are frequently sensitive to drafts, sudden changes of temperature and other factors which lead to chilling of surfaces of the skin and also to changes in atmospheric pressure as with approaching storms. They often report precipitation of attacks by sitting in the breeze of an electric fan, by entering an air-conditioned room or train or by the approach of cold, rainy weather.

In myalgia stiffness is not increased on disuse of the muscle, and symptoms are not relieved by mild exercise. In fact the contrary is true. The symptoms are not increased by fatigue or greatly relieved by rest or food, and there is no marked diurnal variation in symptoms. Salicylates which give so much relief from fibrositis produce little or no relief from myalgia.

**The Clinical Pattern of Myalgia.**—The clinical pattern is as follows: 1. The pain of myalgia is a deep referred pain which is slow in onset and remission and is nearly always unilateral. 2. It rarely appears before the second or third decade of life and may have been ushered in by infection or severe exposure. 3. Tender areas tend to appear and recur in certain definite muscles. 4. Myalgia of the head and pharynx is not infrequently associated with other conditions thought to be due to physical allergy. These are the vaso-atonic (vaso-dilating) pain syndromes, Meniere's disease and vasomotor rhinorrhea. 5. Severe exacerbations of headache may be produced by environmental changes, such as approaching storms, damp rainy weather, drafts, air conditioning and the like, or by severe emotional perturbation. 6. "Jelling" as in fibrositis is not present, and no relief is afforded by mild exercise. Even the slightest use of the involved muscles tends to make the condition worse. 7. The salicylates produce slight to moderate relief of the pain and tenderness. 8. In contrast to fibrositis, no permanent or transient pathologic change can be demonstrated by biopsy.

The average patient with myalgia complains of a severe frontal or temporal headache but on questioning will admit to an additional aching pain in the nuchal region of the homolateral side. Palpation will reveal tender parts in certain muscles. Pressure over these areas will sometimes produce an exacerbation in the frontal or temporal headache. Injection of a strong saline solution into the tender area in muscle will always result in an exacerbation of the pain. Infiltration of the tender portion of the muscle in the nuchal region with 2 per cent procaine hydrochloride will abolish the referred frontal headache temporarily and sometimes more or less permanently. Infiltration of the region of reference with procaine (the area of headache in the frontal region), has no effect on the pain.

The Treatment of Myalgia.—Seydell,<sup>10</sup> who was the first to ascribe an allergic cause to myalgia, advocated the simple home remedy of painting the tender areas with melted paraffin to produce heat and use of massage. Since the evidence is convincing that myalgia is an allergy and, therefore, is associated with a fundamental arteriolar vaso-spasm, the use of various vasodilators has been suggested.

It is of course recognized that heat is probably the earliest vasodilator used by man and used empirically before the mechanism of vasospasm was suspected. Massage is an effective method of eliminating excessive interstitial fluid, such as that which forms when increased capillary permeability is present.

Relief in myalgia may be obtained by application of heat and by massage to the tender areas but such treatment tends to accentuate the symptoms at first, though if continued three or four times a week for four to six weeks, it will succeed in relieving the symptoms more or less permanently.

Vasodilators are used in myalgia as stated on the hypotheses that allergies are always associated with an underlying arteriolar vasospasm and that a vasodilator will "unlock" such a spasm and carry toxic products in the capillary loop to be metabolized in the general circulation and restore oxygenation to the affected area. This would tend to abolish the sympathetic reflex set up by the vascular spasm itself and allow the circling impulses in the internuncial neurone systems hypothesized by Lorente de No<sup>11</sup> to die down.

Several vasodilators have been suggested for use in these conditions. Papaverine, grain 1/4 (0.016 gm.) injected intravenously is probably the first to be suggested but it has not enjoyed great favor, possibly because of insufficient dosage.

Brown and Horton<sup>12</sup> suggested the use of histamine in allergic conditions. Histamine can be used with success as a vasodilator in myalgia but it must be used with caution as excessive dosage will tend to make the condition worse. There is marked individual variation in the reaction to histamine. In the myalgias it is best to start with 0.1 cc. of a 1 in 10,000 dilution of histamine diphosphate administered subcutaneously and increase the dose by 0.1 cc. at twice daily injections until the condition is relieved.

The dose giving relief (the optimal dose) should not be exceeded<sup>13</sup> or symptoms will be precipitated again.

I have found that mono-ethanolamine nicotinate (nicamine Abbott) which has similar physiologic reactions to histamine shows much less individual variation and can be used with much less danger of overdosage. For the average patient (subcutaneous) injection can be started with 25 mg. and increased by a like amount at once or twice daily injections until the optimal dosage, which is usually about 100 mg., is being received. When symptoms begin to be relieved, which is usually in three to five days, the dose is reduced by giving injections once daily. This dose may be continued for a month and then gradually reduced by lengthening the interval between doses, first to every other day for one week, then three times a week for a second week and then twice weekly. The injection may then be stopped. If, at some future time, as the result of exposure to a preferred stimulus the symptoms tend to return, treatment may again be instituted by injection of 25 mg.; dosage may then be built up to the optimal dosage and continued at that level once daily for a week and then discontinued. Such "booster" shots given now and then at the first reappearance of symptoms will usually maintain relief. Relief is usually obtained for from three months to a year. If the condition recurs, it may be found that a larger dose is necessary to reach optimal results. Altitude also has been found to influence results, some patients finding that it requires two to three times the dosage to achieve results at 5,000 to 10,000 feet than is required near sea level. Patients may be instructed in giving themselves the subcutaneous injections.

Treatment may be attempted by oral medication with vasodilators, but I have found that a definitely larger percentage of patients with myalgia will secure relief by subcutaneous injection. Nicotinic acid may be given by mouth but from two to three times the dosage given subcutaneously will be found necessary. Nicotinic acid tartrate (roniacol) also can be used successfully. I have found some individuals extremely sensitive to this drug so that I start with 25 mg. by mouth three times a day before meals and at bedtime. This may be increased by 25 mg. a dose each day until 100 mg. are being

taken at each dose. Oral medication, as stated before, is not as successful as a rule as subcutaneous medication, but its added convenience for some individuals often makes it worth a trial.

*Headaches Arising From Vascular Structures About the Head.*—The headache arising from vascular structures always has the deep type of pain and tends to be referred along the ramifications of the vascular tree. Lewis<sup>14</sup> has shown that when pain is present in working muscles under ischemic conditions the vessels are dilated and collapsed during pain. Ray and Wolff<sup>15</sup> demonstrated that while overdilatation of a vessel produced pain, constriction of the same vessel did not produce pain. Headache, therefore, is not the result of vasospasm, as has been frequently stated, but results from atony of the vessel wall. The term, "vaso-atonic headache," therefore, is suggested for pain of head arising from vascular structures.

Headaches in febrile conditions are produced by an increased cardiac output acting without a compensatory increase in arterial tonus. This results in increased pressure impulses against overstretched arterial walls and pain.

Headache is not produced by increasing the pressure of the spinal fluid if tugging on pain-sensitive vascular intracranial structures is not produced. Thus lesions tending to produce a slowly progressive increase in pressure in the spinal fluid such as is encountered in intracranial hypertension (otitic hydrocephalus) are painless, while sudden changes in intracranial pressure, such as may be caused by intraventricular cysts and tumors, produce severe paroxysmal headaches by suddenly increased tension on vascular walls. These sudden headaches associated with change of posture, with equally sudden relief and with occasional vertigo, nausea and vomiting are readily confused with vascular headache of the "histamine cephalalgia" type but fortunately are rare. However, it goes almost without saying that a roentgenogram of the head, examination of the ocular fundi and a neurologic examination should be made on a patient who has severe intractable headache.

The headaches arising from the blood vessels in the head, therefore, may be divided into the vaso-atonic (vaso-dilating) headaches observed with febrile disease; the vasodilating (vaso-

atonic) headaches in association with anoxia and the release of histamine (the "histamine cephalalgia" described by Horton and co-authors)<sup>16</sup>; migraine produced by a somewhat similar autonomic mechanism; headaches produced by tugging on intracranial vessels, and the rare "intermittent claudication" type of pain encountered usually in older patients, also described by Horton,<sup>17</sup> which is observed in temporal arteritis.

*Sphenopalatine Ganglion Neuralgia.*—Sluder<sup>18</sup> described a unilateral pain in the head, the "lower half headache," which can be relieved by anesthetization of the sphenopalatine ganglion by injection with procaine hydrochloride or phenol and alcohol. The pain also can be relieved by cocaineization of the nasal mucosa in the region just posterior to the posterior tip of the middle turbinate. This pain Sluder<sup>19</sup> considered to be due to antidromic impulses travelling by the parasympathetic fibers which pass through the sphenopalatine ganglion. Accordingly, he termed it "sphenopalatine ganglion neuralgia." In a review of the literature on transmission of painful impulses by the autonomic system, Higbee<sup>20</sup> pointed out that transmission of pain by fibers of the autonomic nervous system could not be confirmed by any investigators and came to the conclusion that whatever the cause of the pain and its method of transmission, it could not be owing to involvement of the parasympathetic system. Dysart<sup>21</sup> suggested that relief of the pain by anesthetization of the sphenopalatine region in the nose was produced by interrupting a reflex arc to blood vessels involving sympathetic fibers from the sphenopalatine ganglion.

Peritz<sup>22</sup> noted the association of neuralgic pain over points where cranial nerves perforate the skull with myalgia of the head. The frequent association of myalgia of the head with vaso-atonic (vasodilating) pain has been pointed out previously. I have found by occluding the external carotid artery on the homolateral side that the pain of so-called sphenopalatine neuralgia can be markedly relieved or completely controlled only to come flooding back on release of pressure. It is felt, therefore, that the genesis of "sphenopalatine pain" can be completely explained by considering it to be a vaso-atonic (vasodilating) pain involving branches of the internal maxillary artery.

Milder types of vaso-atonic pain may be read-

ily controlled by the same treatment as outlined for myalgia. In the severe type termed "histamine cephalalgia" by Horton and associates<sup>16</sup>, the intravenous infusion of histamine solution as described by them will occasionally be found necessary to secure relief.

**Migraine.**—Migraine is a periodic headache with complete freedom from pain in the interim. A tendency to its development is inherited. It usually is unilateral and starts before the second decade of life. There is often a preceding aura, usually associated with vasoconstrictive phenomena which disappear with the onset of the phase of vasodilatation. The aura is replaced by a pulsating headache which is associated with nausea and frequently with vomiting. The headache is associated with increased pulsations of the temporal vessels on the side affected and pressure over these vessels or the carotid artery on the affected side will give temporary relief. The headache is not affected by the position of the patient but may be made worse by exercise. The headache may be relieved by drugs which constrict the extracranial vessels, such as ergotamine tartrate, but epinephrine, which is said to constrict the extracranial vessels while dilating the cerebral vessels, will change the location of the pain from the frontotemporal region to the occipital while making it distinctly worse. The severe occipital migraines, which are not relieved by ergotamine tartrate, may be due to dilatation of the cerebral rather than the extracranial vessels.

Pfeiffer, Dreisbach and Roby<sup>23</sup> have offered the hypothesis that migraine headache is perhaps due to fluctuations of the effective blood volume acting against vessel walls which have not compensated for the change by alterations in tonus. This hypothesis accounts for many of the vagaries of the migraine syndrome; namely, the onset at puberty and frequent relief at the menopause (correlating with the onset and waning of the cyclic activity for the sex hormones with their salt and water retaining properties); the increased incidence in the female over the male (due to the greater salt and water retaining power of the estrogens as compared to the androgens); relief of migraine by pregnancy in which a normal concomitant increase in the blood volume obtains. In the hypothesis it must be assumed that an underlying familial defect exists.

The most effective relief for an attack of severe migraine appears to be dihydro-ergotamine (D. H.E. 45) given intravenously. Often 1 mg. will be ineffective and 2 mg. as the initial dose will prove more effective than repeated doses of 1 mg. It may be found that the headache will be relieved while nausea and vomiting are unaffected or even made worse for a time. If the headache is relieved, however, the attack will be found to be definitely shortened.

Caffeine alkaloid, 100 mg. with 1 mg. of ergotamine tartrate (cafergone), given at the first sign of headache and repeated at hourly intervals for four doses will be effective in some cases. It is the rule for patients with migraine, however, to delay medication until the headache is well established and in such instances this drug often will fail to give relief.

Treatment with vasodilators, such as monoethanolamine nicotinate or histamine, will frequently prove disappointing in true migraine, even though there are definite similarities in the mechanism of migraine, vaso-atonic (vasodilating) pain and myalgia.

**Histamine Cephalalgia.**—Histamine cephalalgia which was originally recognized by Horton is the most severe type of vaso-atonic or vasodilating pain. It is a periodic headache, usually unilateral, appearing in the third decade of life or later. It can be precipitated by alcohol or by the injection of 0.33 mg. of histamine bisulfate (insufficient to produce a histamine headache) after a latent period of fifteen to thirty minutes. There are no preceding vasospastic phenomena or aura and usually no pulsation to the pain. The headache frequently appears at night and in the early morning hours, waking the patient from sleep, and is of the highest intensity. It appears suddenly, is usually of relatively short duration, and disappears as suddenly as it comes. The pain tends to be relieved on assumption of the erect position; carotid compression also gives temporary relief, but the pain reappears immediately on restoration of the blood flow. Histamine cephalalgia is associated with signs of cholinergic hyperactivity of the homolateral side such as congestion of the nasal mucosa, vaso-motor rhinitis, vasodilatation of the skin vessels, conjunctival injection and lacrimation. It occasionally is associated with Meniere's disease and myalgia of the head as

well as vasomotor rhinitis. The physiologic mechanism of histamine cephalalgia appears to be similar to that of myalgia, in other words a localized arteriolar constriction with capillary and venular dilatation of the vasa vasorum of the affected artery producing anoxia. Release of histamine and increased interstitial fluid into the adventitia of the wall of the affected artery with secondary relaxation of smooth muscle of the arterial wall is the origin of the pain. Flushing out the affected capillary loops with vasodilators, tends to relieve the symptoms. The treatment for myalgia and vaso-atonic pain is the same since it appears that both are instances of cholinergic hyperactivity.

Since some difficulty is sometimes experienced in differentiating migraine from "histamine cephalalgia," the clinical patterns of these two, probably related conditions, may be contrasted. This differentiation is important from the standpoint of treatment.

#### THE CLINICAL PATTERN OF MIGRAINE

1. Migraine usually begins at puberty (the second decade or before).

2. A family history of similar headaches can usually be obtained.

3. A history of an aura, usually visual symptoms, can be obtained in about a third of all cases.

4. The onset of the headache is slow; the pain gradually rises to a maximum and gradually subsides.

5. The pain is of the deep type, is usually unilateral and is pulsating; it can be relieved by lying down and sleeping and can be partially controlled by pressure over the temporal vessels.

6. An attack frequently is precipitated by excitement, nervous fatigue, over-relaxation, hunger or menstruation. An attack is not precipitated by small doses of histamine.

7. An increase of the flow of urine frequently occurs before or during an attack.

#### THE CLINICAL PATTERN OF HISTAMINE CEPHALALGIA

1. An inherited tendency toward various types of autonomic dysfunction can often be discovered.

2. The onset of histamine cephalalgia is usually in the third decade of life or later, and its first appearance may follow stress such as an acute

infection, or an exposure to the elements of an emotional storm.

3. No aura is present.

4. The pain is sudden in onset, of relatively short duration and sudden in termination, and frequently wakes the patient from sleep.

5. The pain is usually unilateral but may be midline or bilateral. The recumbent position tends to make the pain more severe, and the patient assumes the erect position because of the relief of pain produced. The pain may be temporarily controlled by carotid pressure. Carotodynia will be found to be present.

6. An attack may be precipitated by ingestion of alcohol. A test dose of 0.35 mg. of histamine phosphate (insufficient to produce a histamine headache) will precipitate an attack after a latent period. Exposure to severe cold will sometimes precipitate an attack.

7. Histamine cephalalgia is usually associated with evidences of cholinergic overaction on the homolateral side, such as nasal congestion and discharge and lacrimation.

#### COMMENT

In this paper some of the commoner types of headache have been considered. It is felt that a careful differential diagnosis of these headaches is important because they comprise the large majority of headaches, and if they are properly differentiated, they will yield to simple office treatment well within the reach of any practicing physician.

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## BONE CHANGES WITH AGE

Degenerative changes in the structures of bones and joints represent an important component of the aging process. Such alterations are readily apparent to the clinician as well as the radiologist. Structural changes in bones primarily are of two types: generalized osteoporosis, and the single or multiple focal lesions of osteitis deformans (Paget's disease). Atrophy of the joint cartilages with secondary proliferative changes in adjacent bones and soft tissues comprises the disease known as degenerative disk disease or degenerative arthritis, according to its anatomic site.

The clinician notes the decrease in height with age due to dorsal kyphosis based on atrophy of the vertebrae and degeneration of the intervertebral disks. There may be bowing of the

extremities and enlargement of the skull as a result of osteitis deformans, and in some patients the knobby joints of senescence as the result of degenerative arthritis. The clinician must be aware of important pathologic sequelae associated with alterations of bones and joints. Pain in the back as a result of collapse of the demineralized vertebral column is a common symptom, locomotion is impeded, and the large weight-bearing joints such as the knees and hips may reflect the wear and tear to which they have been subjected. Exogenous influences such as trauma, infection, and circulatory disturbances are important factors which further influence the skeleton already involved by the manifold changes of higher years. *Editorial, Metabolic Bone Changes With Aging. Pennsylvania M.J., Nov. 1953.*

# Coronary Heart Disease

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Coronary heart disease is our number one killer. It is not remarkable, therefore, that a tremendous amount of basic and clinical research has been directed toward its management. But, in view of our ignorance of the basic cause of atherosclerosis, it is not remarkable that this research has resulted in many differences of opinion as to what constitutes adequate management. These differences apply equally to the important questions of rest, diet, and drugs. No single authority is capable of resolving these differences for you at present, and I certainly would not presume to try. However, I am convinced that we, as individuals, can better judge the relative merits of conflicting proposals if we possess a reasonable knowledge of the pathological physiology of this disorder.

## MECHANISM OF CORONARY INSUFFICIENCY

The term "coronary insufficiency" should be used to indicate a discrepancy between supply and demand of blood and oxygen to the heart muscle. Factors responsible for coronary insufficiency may be outlined as follows:

*I. Coronary Factors:* Of prime importance are the structural changes in the coronary arteries which reduce their lumen. Atherosclerosis is the responsible agent in over 90 per cent of the cases. Much less commonly we recognize embolism, thromboangiitis obliterans, periarteritis nodosa, and various other forms of arteritis.

The functional factor, or vasoconstriction, is capable of producing coronary insufficiency, particularly when superimposed on structural changes. This vasoconstriction may result from vasomotor reflexes or chemical stimuli. The vasomotor reflexes may be of cardiac origin and result from ischemia or infarction of the myocardium. The effect is to increase the degree of insufficiency and to extend the area of injury. These vasomotor reflexes may also be of visceral

origin, and it is well known that gall bladder disease, hiatus hernia, or even a large meal increases coronary insufficiency, as manifested by angina pectoris.

Chemical causes of coronary vasoconstriction may be of limited importance. Ergotamine, pitressin, and potassium are examples of drugs, hormones, and metabolites respectively known to produce coronary vasoconstriction.

*II. Extra-Coronary Factors:* Extra-coronary factors contributing to coronary insufficiency include impaired coronary blood flow, poor oxygen saturation of the blood, and increased demand on the heart. Low diastolic or mean pressure at the base of the aorta reduces coronary flow. Important situations wherein this is operative are shock, aortic insufficiency, and patent ductus arteriosus. As coronary flow takes place only during diastole, marked shortening of this period also will decrease flow. This reduction is observed in tachycardia of whatever cause. Conditions that lessen coronary flow are known to produce angina pectoris, particularly if superimposed on structural coronary changes. The same can be said of poor oxygen saturation of the blood which may occur in anemia, congestive heart failure, and pulmonary and congenital heart disease.

Increased demand on the heart is an important extra-coronary factor in the production of coronary insufficiency. Effort and excitement are well-known precipitating factors of angina pectoris. The importance of increased blood volume is less commonly appreciated. It has been estimated that the decubitus or horizontal position augments blood volume 15 per cent. This explains in part the phenomenon of angina decubitus. Hypertension and obesity add to the work of the heart as well as to its oxygen demand.

## MANIFESTATIONS OF CORONARY INSUFFICIENCY

What are the manifestations of coronary insufficiency? They may be arbitrarily divided into clinical, pathological, and compensatory. Clinical manifestations include pain, dyspnea and,

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depending on the severity of the insufficiency, shock and other signs of myocardial infarction. Pathological manifestations are myofibrosis, or diffuse scarring, on the one hand and frank infarction on the other. So far as compensatory manifestations are concerned, the development of collaterals and anastomoses depend upon the existence of coronary insufficiency, and these are the changes which make for survival in coronary heart disease.

#### IMPORTANCE OF CONCEPT

An understanding of the clinical importance of this concept of coronary insufficiency began with the work of Blumgart and Schlesinger in 1940. By injection methods they were able to demonstrate coronary occlusion without myocardial infarction and myocardial infarction without coronary occlusion. Widespread collaterals make possible occlusion without infarction and, as mentioned previously, this is vital factor in survival. Infarction without occlusion depends upon the functioning of the extra-coronary factors discussed. This infarction depends upon some structural narrowing of the coronary vessels with the extra-coronary factors aggravating ischemia to the point of frank infarction.

#### COURSE OF INFARCTION

In considering the pathological physiology of myocardial infarction, we have listed ten events operative in infarction which are more or less but not necessarily chronological:

1. Acute occlusion or insufficiency
2. Acute ischemia
3. Hypodynamic action
4. Vasomotor reflexes
5. Peripheral hyperexcitability
6. Necrosis
7. Mural thrombosis
8. Phlebothrombosis
9. Congestive failure
10. Psychic disturbances

The chain reaction starts with acute occlusion resulting from intimal thickening, subintimal hemorrhage, or thrombosis of a coronary artery; not infrequently, there are aggravating extra-coronary factors. It should be recognized that an extra-coronary factor increases in importance with the time during which it is operative. The immediate consequence of occlusion or marked insufficiency is acute ischemia, the area depend-

ing upon the size of the vessel and the presence or absence of collaterals. Ischemia, in turn, leads to hypodynamic action of a portion of the myocardium with loss of contractile power. This may markedly reduce the output of the heart, resulting in hypotension and shock. Shock further reduces coronary blood flow. In the favorable case a compensatory mechanism comes into play and the blood pressure may rise, provided there is sufficient viable myocardium.

Cardiac vasomotor reflexes with resultant vasoconstriction of adjacent vessels tend to increase the area of injury, as mentioned previously. The periphery of the area of infarction becomes hyperexcitable. This results in paroxysmal heart action which may lead to ventricular fibrillation, a common cause of death in myocardial infarction. Hyperexcitability also results in pain, dyspnea, vascular collapse, anxiety, and nausea and may contribute to early pulmonary edema.

Necrosis develops in the center of the area and in a large infarct, may be transmural. Necrosis is most marked between the fifth and eighth days and rupture of the heart ensues in approximately ten per cent of fatal cases. Necrosis is followed by fibrosis, or scarring, which may produce congestive failure. If the wall of the ventricle is markedly thinned, aneurysm forms in approximately 10 per cent of major infarctions. Mural thrombosis develops if the infarct extends to the subendocardium. This occurs in approximately 50 per cent of major infarctions and is the source of emboli to the brain, spleen or kidneys. Phlebothrombosis, predominantly in the leg veins, is presumed to result from venous slowing and inactivity. This is the source of serious and often fatal emboli to the lungs.

Congestive heart failure is frequent and may be severe during the early period due to hypodynamic action of the heart. It is commonly manifested by pulmonary edema. Later in the course of the illness, chronic congestive failure may arise with typical venous engorgement plus water and electrolyte imbalance. Psychic disturbances may be marked, with the initial anxiety and restlessness contributing as extra-coronary factors to coronary insufficiency. The subsequent fear and depression set the stage for the later development of a cardiac neurosis.

## TREATMENT OF INFARCTION

We might consider briefly 10 objectives in the treatment of myocardial infarction. The more controversial issues will be avoided.

*Reduce Work of the Heart:* Bed rest is imperative, but the degree and duration should depend upon the severity of the individual case. There is a current and enlightened trend toward earlier ambulation with recognition of the fact that sitting in a comfortable chair may sometimes rest the heart more than lying in bed. Sedatives, light diet, and the use of a bedside commode are further measures designed to reduce the work of the heart.

*Alleviate Pain and Anxiety:* Morphine holds first place. It should be given in sufficient quantities and intravenously, if necessary. Occasionally oxygen and intravenous aminophylline may be employed.

*Check Autonomic Reflexes:* This may be accomplished, in part, by the routine use of quinidine sulfate, grains 3 every six hours, plus sedatives. Of questionable value are atropine, papaverine, and pronestyl.

*Combat Hypotension and Shock:* This results from vascular collapse with peripheral pooling as well as hypodynamic action of the heart. Morphine, properly used, helps to combat the former. Those cases not responding to morphine may be given sympathomimetic drugs, such as norepinephrine, by continuous slow intravenous drip. The use of venous and arterial transfusions is more controversial.

*Prevent Extension of Infarct:* This is done, in part, by meeting the previous objectives and may be furthered by the use of an anticoagulant, which may prevent the propagation of a coronary thrombus.

*Prevent or Treat Arrhythmias:* The routine use of quinidine is advisable. Certain types of arrhythmia may call for digitalis or pronestyl. The major purpose is to avoid the dreaded ventricular fibrillation.

*Prevent or Treat Heart Failure:* This is not entirely preventable, particularly during the

early stages, due to hypodynamic action of the heart. Oxygen and morphine should be used for pulmonary edema. A low sodium diet, digitalis, and mercurial diuretics are useful in congestive failure.

*Prevent Mural Thrombosis:* This is accomplished partly by limiting the area of infarction but is best accomplished by the use of an anticoagulant.

*Prevent Phlebothrombosis:* This may be accomplished by early active movement of the legs, the so-called Chair treatment, and early ambulation. Here, again, anticoagulants are of recognized value but many competent authorities feel they should be used only for major infarctions and in individuals who for one reason or another have a high susceptibility to thrombo-embolism.

*Maintain Morale:* The patient who has suffered a major infarction has passed through the valley of death. He needs morphine and sedation but he needs also immediate and continued reassurance from his physician. Emphasis should be placed on the favorable aspect of recovery and ultimate rehabilitation. He should not be stretched out like a cadaver and fed by a nurse. It is better to encourage him to move about in bed and to feed himself at the earliest possible moment. Unnecessary use of oxygen must be avoided. Early ambulation, with the use of a comfortable chair at the side of the bed, will shorten the period of depression and anxiety which plagues recovery. We ought to avoid unnecessary restrictions and taboos during the subsequent weeks of convalescence. We must keep in mind the old bromide about the patient who was told by his physician that he had heart disease. The physician enumerated a long list of restrictions, including smoking, drinking, golf, attendance at athletic events, and intercourse with his wife. Hereupon the patient asked, "Well, Doctor, if I give up all these things, will I live any longer?", to which the physician, who was inherently honest, replied, "No, but it will seem longer."

# Ophthalmology in Rural Areas

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A few months ago the chief of an eye department in an Eastern teaching hospital was asked to recommend one of his residents for a rural eye practice. He quickly replied that most of his residents preferred the city with its large hospitals, its scientific associations, its facilities for research and consultation and the organized team-work of its operating rooms. The same chief pointed out that a number of his pupils had gone to small towns and, lacking the stimulus of large centers, had returned to the metropolitan area.

This attitude is slowly changing, because the tremendous need for ophthalmic service in rural areas is being more and more recognized. Metropolitan areas had proper facilities for many decades and expert advice was readily available privately or, for the indigent, in public institutions. Rural areas were less fortunate in this respect and frequently lacked ophthalmologists who had formal training which could be regarded as adequate. The colleagues in smaller towns sometimes had only a post-graduate course of a few months duration or acquired the title "specialist" by a six months journey to Europe. These were excellent means to round out an education, but, by themselves, were not sufficient to make for a safe ophthalmologist.

The non-medical refractionist of those olden days likewise had had only a few weeks or months of formal education, sometimes for no other reason than to open the way for a profitable commercial enterprise. The medical profession had no desire to cooperate with these men or to even recognize professional aspects of optometry. On the other hand, there was little that the general practitioner of medicine remembered from his short lectures in medical school about the diseases of the eye. He simply was not interested in them. Public health measures for the prevention of blindness were in their infancy and ocular public health agencies frequently did not find the cooperation of local physicians

in private practice, even though these public endeavors did concern themselves with eye problems which could not be solved by private practitioners alone.

It was the result of these conditions in rural ophthalmic care that blind pension examinations in rural areas during the past ten years turned up many cases, in which proper care would undoubtedly have saved or preserved vision. The over-ripe cataract with glaucoma, the unrecognized detachment, the adult with strabismus fixus, the over-grown pterygium, the occluded pupil after uveitis, the dense pannus of a far advanced trachoma, the absolute glaucoma who never had seen a tonometer, never had a field, or heard of the possibility of surgery, when drops failed to control tension — all these are instances of showing up the need for good responsible eye care in rural areas.

During the past two decades considerable progress has been made in the fulfillment of this need.

In the public health field, spearheaded by the untiring efforts of the Illinois Society for the Prevention of Blindness, gonorrheal ophthalmia of the newborn and trachoma have been virtually wiped out. The former subsided in consequence of the mandatory silver nitrate law, passed in 1933, the latter has decreased to a near vanishing point as a result of the establishment of special treatment centers in combination with the advent of sulfa drugs and antibiotics and generally improved living conditions. Not counting the savings in human suffering alone, the saving in blind pension funds far outweighs the public cost of the initial expense.

Regular systematic testing of school children by means of the Massachusetts vision test is discovering many young people with defective sight or muscle imbalances who otherwise would not receive attention until much later in life. This program again is under the sponsorship of the Illinois Society for the Prevention of Blindness, makes extensive use of public health nurses and lay personnel and is supervised by joint committees of oculists and optometrists on the local

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or regional level. Sightsaving classes have been established in many of the larger communities to aid pupils with subnormal vision or high myopia. In districts where this is not feasible, due to lack of sufficient numbers of such pupils or other reasons, the books which are used in sight saving rooms and which have special large print are usually made available, whenever the oculist requests it.

The general practitioner plays a most important part in the eye care of the rural population, because on their judgment and treatment rely many cases which in the city automatically come to the attention of the ophthalmologist. In addition, many people would never seek special eye care, would not the simple visual acuity test during the course of a general physical examination uncover an eye defect. The alert family physician becomes, therefore, a sort of detecting station for impending or established ocular trouble. It is also necessary that he has some knowledge of the facilities available to modern ophthalmic care, in order that he may be able to correct such mistaken ideas as "a cataract has to ripe before surgery" or "a child will grow out of crossed eyes." The close contact the rural general physician usually has with the families in his area gives him a splendid opportunity to point out steps for ocular care and attention which would otherwise be neglected.

While interest in ophthalmological problems may vary with each practitioner, a check of visual acuity should be a standard routine procedure and cases seeing less than 20/30 should be referred. Ophthalmoscopy is not difficult and should also be part of a routine check-up. The recognition of a choked disc may save a life long before an oculist is finally consulted for unexplained headaches and hemorrhages or exudates in the retina may be a finding which aids in evaluating vascular or metabolic disease. Every rural general physician should acquire the training and knowledge how to handle a spud for corneal foreign body and should be able to do it competently in a sterile manner. The danger of perforating the cornea is small, but neglect or unsterile procedures may, on the other hand, be disastrous.

The optometric profession plays a significant part in rural eye care and prevention of blindness. The usual reaction of the layman to the symptom of declining sight is one of "I have to

have my glasses changed." In 75 out of 100 cases this thought will lead the patient to an optometrist. It becomes readily evident that a tremendous responsibility rests on any refractionist who becomes the examiner of this patient. Quite certainly, the average layman in rural areas does not differentiate between optometrist and oculist. Both fall to him under the heading "eye doctor." While declining sight may merely mean a need for change in glasses, it may also mean cataract, glaucoma, retinal disease, brain tumor and a host of other pathological entities. Again, the rule, that every patient who sees less than 20/30 should be seen by an oculist is to be recommended. Most children should also have an oculist consultation for the purpose of examination under cycloplegia.

Educational requirements for obtaining license as optometrist have been constantly raised and a good many of the younger men coming out of optometric colleges nowadays have a professional conscience. It is in the public interest that the ophthalmologist in the area cooperates with these men and that he joins them in their efforts to stamp out commercialism in the field of ophthalmic care, not only by educating the public, but by enlightening our legislators that the sight of our citizens cannot be entrusted to people who are solely interested in it from the standpoint of a commercial transaction.

For the ophthalmologist himself rural or small town practice presents certain problems, which do not necessarily exist in city practice. As there is usually no opportunity for help or consultation from other local oculists — he is alone in a wide area — it becomes a basic requirement that his ophthalmological training was thorough enough to make him a dependable diagnostician and to be familiar with all the common and, at least acquainted, with all the rarer methods of treatment available to ocular science. It is desirable that he do reliable surgery. Nobody pays much attention in rural areas, if an oculist is certified, but in the absence of any other criteria by which he could evaluate his professional adequacy the passing of the board becomes a matter of one's own reassurance in dealing with eye patients.

While our routine for examination is the same as it is in the city, one is frequently forced to combine a lot of steps, even the dispensing of

glasses, into one visit, because the patient may live far away and unnecessary visits have to be avoided. Naturally, difficult cases of refraction or muscle imbalance have to have repeated studies. Atropinization of children for three days before refraction is widely employed, but one can substitute a combination of atropine and neosynephrine for 90 minutes in the office and save the patient an additional trip.

Dispensing is a necessity in rural practice, because there are no dispensing opticians and the patient expects a fully integrated service. The correct type of lens in a properly fitted and cosmetically pleasing frame are as important to the patient as is the basic fact that the refraction was a correct one. The best refraction can be ruined by a poor dispensing job. To my mind, dispensing is part of the professional service the rural ophthalmologist renders. He is responsible for it, even though he may employ an aide for certain aspects of this work.

Treatment of ocular disease follows accepted city standards. Laboratory facilities are usually available in the local hospital, but one cannot always expect very exact differential diagnostic details as to a rare type of bacterium or more unusual procedures like tests for toxoplasmosis or highly differentiated skin tests. This is no great drawback, as most acute external eye conditions clear up with one of the sulfa derivatives or an antibiotic or a combination of the two. Many epithelial inflammations of the cornea do likewise, especially when aided by cautery, iontophoresis and cortisone. In deep keratitis, uveitis and optic neuritis an effort is always made to find the etiology. But how often are we looking in vain and how infrequently do we receive a positive report from the family physician from the laboratory, yes even from university hospitals or the Mayo Clinic. Confronted by this overwhelming number of negative investigations we frequently do our own Kahn and Tuberculine tests and rely on non-specific treatment with atropine, cortisone, heat, fever therapy, etc. I doubt that our percentage of success in arresting these conditions is significantly less than in large city institutions.

Vascular and degenerative conditions in retina and choroid also call for general investigation. The rural ophthalmologist has to keep himself informed on the newer general measures for arteriosclerosis, vascular hypertension, diabetes

and kidney disease, in order that he may discuss their possible advisability with the family physician. Specialists in the field of cardiovascular disease or diabetes may not be readily available, some drugs may have to be ruled out due to lack of proper laboratory supervision or because the patient himself cannot be relied upon. Whenever possible, the use of vasodilators, anticoagulants, diet and, where indicated, sympathectomy should be considered in cooperation with the general practitioner. While these measures may prove disappointing for the individual case, they are the best we have to offer to the patient at the present time.

Orthoptic training is at a distinct disadvantage in a rural area. One can hardly demand extended trips several times a week to one's own office or to the large centers in the city to get the benefit of procedures which, combined with all other methods at our disposal, produce perfect binocular vision in less than half of the cases. Proper orthoptic facilities in a single private practice are usually not even feasible for time and economy reasons. Under these circumstances we have to rely on the correction of the refractive error, patching, early surgery and follow-up by home training with stereoscopic exercises. Home training is not the ideal form of orthoptics, but it serves well for increasing fusional amplitudes in cases of normal retinal correspondence.

The eye surgeon who after completion of his training finds himself the lone oculist of the town's general hospital certainly does not have the medical or nursing assistance he had been used to. It is, however, possible to do safe and competent eye surgery with the sole assistance of a nurse, if one adapts the technique to this situation and does not attempt to do procedures which obviously need the facilities of larger centers. We average about sixty cases of major eye surgery annually in St. Mary's Hospital in Centralia, not counting enucleations, tearsacs, pterygia, small lid plastics and so on. These surgical facilities are important to the population of our area, because there is a great reluctance on the part of certain types of patients to go to the city and, especially, to a city hospital.

In cataract surgery one needs no highly trained assistance for two Stallard type sutures, followed by a keratome incision which is enlarged with scissors. A complete iridectomy fa-

cilitates the delivery of the lens and minimizes the danger of prolapse in an ill behaved patient. The intracapsular technique by tumbling is preferred to the one by sliding out from above. The occasional deliberate performance of extracapsular extraction in cases with mature cataracts produces satisfactory visual results and certainly reduces the incidence of vitreous loss.

Iridencleisis and trephine are well within the possibilities of small town surgery. So are procedures for recession or resection on the ocular recti muscles. Surgery on the obliques may also be done, but I prefer to leave it to colleagues who have frequent use for these procedures and are, therefore, fully familiar with it.

Detachment surgery is technically not difficult and can be done in small general hospitals, if proper assistance and understanding nursing care are available. Pre-operative studies as well as surgical procedures demand time, patience and, as Arruga expressed it, "no watching of the clock." The patient will not be satisfied with a mere anatomical reattachment and the surgeon will be judged by the functional success. Considering all this it may be wise to refer the four or five detachment cases one sees during a year to a city consultant who makes detachments his special interest.

While the rural eye physician is alone in his area he should never hesitate to seek the cooperation of reliable and responsible colleagues in other towns or the next larger city, whenever there seems need for a second opinion. It is utter neglect to let a difficult case go on in order to avoid a possible disagreement as to diagnosis or as to methods. The burden of the decision for enucleation or of surgery for advancing compensated glaucoma should always be shared by a consultant. Long drawn out cases of uveitis or keratitis deserve a second opinion for the patient's benefit and for the doctor's peace of mind.

It does not detract from the most efficient eye departments in our city hospitals, if one emphasizes the importance of the task of the rural ophthalmologist. A majority of rural patients would not even obtain early, and possibly sight saving diagnosis, would it not be for his presence, his standing in his area and his cooperation with general physicians and optometrists, making them eye disease conscious. The education of the rural oculist should, therefore, not stop with his leaving his residency. He does

not enjoy the continued advantages of working in large institutions with other experienced men. Lecture courses, books and journals form an important link to one's specialty. But they do not seem enough. Progress is constantly made. Cyclodiathermy, beta irradiation, movable implants, crysophace extraction, gonioscopy, corneal transplants — all are examples of relatively recent progress. One is naturally hesitant to try new steps without the supervision of an experienced colleague. It would, therefore, be a great step forward for the rural ophthalmologist, if ways could be found, whereby he could take up a residency for two or three months every five years in one of the large centers. This would enable him to acquaint himself with new developments, to try new methods and to refresh the efficiency and adequacy of his own techniques.

While we have periodic checks and safety measures in technical fields in the interest of the public, we blandly assume that a state or specialty board passed some decades ago still makes for a safe doctor. Fortunately, the assumption is correct for the majority of physicians. It would, however, greatly enhance the efficiency of practitioners in all fields, if — beyond the scope of mere lectures — they would have facilities to again rub elbows with their colleagues in the wards of our teaching institutions and to rejuvenate their methods, their thinking and last, but not least, their spirit. For the oculist practicing in a rural area it would round out the many satisfactions he derives from his professional activities.

#### S U M M A R Y

Ophthalmology in rural areas has much higher standards today than it was the case only a few decades ago. Expansion in public health measures together with better training within the ophthalmic professions have contributed to a marked reduction in the incidence of blindness. The oculist has to adapt his methods of examination and treatment as well as his surgical techniques to the facilities available to him. Most surgical procedures can be carried out safely and successfully in small town general hospitals. Periodical full time *refresher residencies* of a few months duration are suggested to keep the efficiency of ophthalmologists who practice away from the teaching centers always at peak level.

# Recent Advances in Treatment of Sinus Disease

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Chronic sinusitis at the present time is not regarded as the hopeless condition it was formerly thought to be.

During the past few years considerable research and clear thinking have dispelled much of the confusion formerly associated with the sinuses and as a result, most of the antiquated mutilating operations have been replaced by less radical but more effective procedures.

We, at last, have come to realize the importance of the role played by the various structures in the nose including the ciliated mucosa which lines the nasal and sinus cavities and the moving film of mucus covering it. We know that in the mucociliary mechanism we have a primary defense against infection, for the pathogenic organisms entering the nose are picked up by the sticky mucus and destroyed. It is also known that in the event of a breakdown in the mucociliary mechanism an able secondary defense awaits the invaders in the subepithelial layers of the membrane for here through the capillary walls pour powerful inflammatory cells to attack and destroy the bacteria and carry them to the surface. In a sinus cavity pus is thus formed and immediately waved toward the drainage outlet by the cilia.

In the early stages of sinusitis, the ostium is usually blocked by acute congestion and the pus remains in the cavity causing pain and toxic symptoms. As local immunity becomes established, the swelling subsides, the opening becomes patent and the exudate pours into the nose. In unhampered cases, the infection gradually diminishes and will heal spontaneously in a week or two, but often barriers are present which

prevent free drainage and the infection lingers on. Should nothing be done to provide adequate drainage a state of chronicity develops.

Medical Care and Management of Acute Sinusitis. — In the early stages, very little treatment is indicated or of value. Patients are put to bed when possible in a warm, well-moistened room and efforts are confined to the relief of symptoms and prevention of complications. Pain is relieve by sedatives and heat, moist or dry over the affected area, and if the nasal blockage is severe it may be lessened by the instillation of carefully selected nose drops. These drops are best applied with the patient in the position of Proetz with the head low over the edge of the bed or treatment table. The ideal preparation is a normal saline solution containing one per cent ephedrine. Synthetic preparations such as Neo-Synephrine Hydrochloride (0.25%) or Rhinalgan are satisfactory. These drops afford temporary relief but contribute little toward the cure of sinusitis. They should be used sparingly for it is questionable if anything should be done to combat tissue swelling which is merely the natural physiological response to the disease as are an elevation of the body temperature and an increase in the leucocyte count.

Other measures, advocated by certain writers, but which are of no proven value, are short wave diathermy and x-radiation. Tamponage with argyrol and neo-sivol, although in common usage probably does more harm than good.

Anti-Microbials. — Parenteral penicillin and other antibiotics are on occasion effective aids in the management of attacks of acute sinusitis, particularly in the more severe types but they should not be expected to produce a cure in the ordinary case when used as the sole measure of therapy. Cases are commonly encountered by rhinologists which have failed to show improvement after several days or weeks of antibiotic therapy. As a rule nothing has been done in

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these cases to improve sinus drainage which is what is needed most to terminate the infection. The antibiotics tend to keep the infection localized and under control, but it is regarded by rhinologists generally as far better practice to withhold their use in the ordinary case until such time as the other available measures fail to prove effective. This not only is because of the questionable aid to be gained by the antibiotics, but because they fear the toxic and masking effects likely to be produced along with the likelihood of development of resistant strains of bacteria and because they prefer to hold in reserve these valuable agents against the development of complications when their use will be more greatly appreciated.

Penicillin and other antimicrobial preparations instilled into the sinus after lavage are of no appreciable value, for the micro-organisms responsible for the disease are located at various depths in the sinus mucosa and thus can be reached only by blood borne remedies.

Irrigation of a sinus is instituted as the acute congestion subsides. If the maxillary, frontal or sphenoid sinuses are involved irrigation through a cannula is required, but if the ethmoid cavities are affected an effective removal of accumulated secretions may be attained by means of displacement therapy.

**Management of Chronic Sinusitis.** — In the management of chronic sinusitis simple measures if properly carried out suffice in a majority of cases. Since the inception and maintenance of the disease is in most instances due to blocked drainage passageways efforts are concentrated on correction of such defects as may be responsible for drainage impairment.

In most cases of a few months or even years duration the ostium itself is not at fault but rather the trouble lies in the relations of the tissues adjacent to the ostium.

Considerable improvement in many cases follows minor procedures which unblock the middle meatus. In some instances a septal resection

is required so as to permit adequate infraction of the turbinate and in others turbinal cells must be obliterated. In some cases, removal of a polyp may correct the blocked drainage area.

Allergy plays an important role in most cases of recurrent or chronic sinusitis both in the etiology and in the maintenance of the attack, and many of the stubborn cases of sinusitis are those in which the allergy has been overlooked or neglected. Attention must also be directed to other possible systemic disorders and allied inflammatory conditions in other sinuses as possible contributing factors to the persistence of the infection.

At the outset, diagnostic lavage is carried out in those cases in which sinusitis is revealed or suspected by x-ray or other diagnostic measures. Irrigation is repeated at weekly intervals, once the diagnosis is made. This procedure serves the dual function of ridding the cavity of toxic secretions and throwing light on the progress of the disease. Further information is gained by occasional roentgenologic studies with the sinus filled with iodized oil. Frontal and lateral views are taken and in these, changes in the thickness of the sinus mucosa may be determined. It has been noted repeatedly that as the mucosal edema recedes, there is a general improvement in the symptoms.

If relief is not obtained an adjunct drainage opening known as a window, is required. This may be placed in the anterior wall of the sphenoid sinus or in the medial wall of the antrum at its lowest point. In the treatment of chronic maxillary sinusitis the window operation when properly carried out is a highly successful procedure. The effects are immediate and lasting and with its widespread adoption of the past few years the window operation has practically eliminated the need of the radical Caldwell-Luc procedure.

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# Recent Advances in Studies of Virus Infections of the Nervous System

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The detection and identification of virus infections have been placed on a satisfactory basis by means of sensitive and specific reactions which are counterparts more or less of the same techniques used in bacterial infections. In many instances the virus agent cannot be recovered from the living human host, but often indirect evidence obtained by serological methods may be demonstrated. I do not propose to do more than briefly evaluate the recent laboratory diagnostic procedures that have become available as techniques which can be used to identify invading viral agents. These are by no means always simple or readily available techniques, but they do emphasize the importance of early clinical findings to help overcome the limitations of the laboratory laboring to help make an accurate diagnosis. The individual viruses or virus groups are therefore briefly considered in the light of recent diagnostic advances. I have for the most part listed them individually in order to emphasize their consideration in the laboratory study of the patient. I do not intend to discuss viral antigens since of necessity research is continuously underway for specificity in laboratory diagnosis.

Influenza, while a respiratory disease, has been incriminated since the World War I pandemic as causing damage to the central nervous system. Two major antigenic types, A and B, exist for influenza,<sup>1, 2</sup> but there also exist numerous sub-strains including an A prime (A')<sup>3</sup> and a new possible C type.<sup>4</sup> The main procedures used for laboratory diagnosis are isolation of virus from throat washings into amniotic<sup>5</sup> or allantoic sacs of fertile eggs, and virus presence detected by hemagglutinating ability<sup>6</sup> for avian, guinea pig, and human type O cells. Serological comparisons are made by complement fixation, using allantoic fluid or mouse lung antigens,<sup>7</sup> and

agglutination-inhibition tests using sera collected during the acute and convalescent stages. A negative serological test or negative virus isolation does not rule out infection, while a demonstrable rise of serum antibody with acute and convalescent sera is significant of influenza infection. It must be borne in mind, that in frequent cases the isolation of virus, and the convalescent antibody titer may both be negative. In order to make a laboratory diagnosis of influenza valid the clinician should early consider the question of influenza, since silent or inapparent infections show significant rises in antibody.

Laboratory tests for mumps virus infection in cases of meningoencephalitis<sup>8</sup> are used to confirm or establish the diagnosis; these tests are similar to those used for influenzal virus activity. Mumps virus may be isolated directly from saliva, or spinal fluid from early cases of meningoencephalitis into the amniotic sac of the chick embryo, and virus identified by hemagglutination of chicken red cells.<sup>9</sup> The virus isolated may be identified by neutralization tests with known immune serum in the chick embryo; by complement fixation tests with acute and convalescent sera, using as the antigen amniotic fluid infected with the new strain; and also hemagglutination-inhibition of the virus by high titer immune serum. Serological diagnosis of mumps is most reliably made, and earliest, by the complement fixation test. The hemagglutination-inhibition test may infrequently give high neutralizing titers with mumps convalescent sera, but it is also a fact that normal seras are also capable of inhibiting the hemagglutination to some degree. In cases of mumps the difference between acute and convalescent seras in their hemagglutination-inhibition titers is often small, placing the data in a questionable category. To a certain extent the hemagglutination-inhibition test for mumps suffers in comparison to influenza virus. Following intradermal inoculation<sup>10</sup> of

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inactivated mumps viral antigen, most immune persons exhibit erythema and induration, but exceptions are frequently seen. The reliability of the intradermal skin test is difficult at present to evaluate, and it is suggested that the combination of complement fixation test, hemagglutination-inhibition test and skin test be used.

Lymphogranuloma venereum may in rare cases exhibit meningitis<sup>11</sup> or pneumonitis. Pus from bubo, or biopsy material from buboes, rectal or anal lesions may be inoculated intracerebrally into mice or yolk sac of chick embryos,<sup>12</sup> and virus detected by presence of elementary bodies after further passage. The most reliable test is the intradermal<sup>13</sup> sensitivity to inactivated yolk sac viral antigen during the acute and convalescent phases. Complement fixation with special antigen appears to be specific for acute and convalescent sera, but not as reliable as the skin test findings.

Viruses can cause pneumonia, and primary atypical pneumonia is included here since influenza virus, lymphocytic choriomeningitis virus, and the psittacosis-lymphogranuloma inguinale group of viruses as well as rickettsiae, can cause human pneumonia. It is ten years since I reported the absence of a valid filterable etiological agent<sup>14</sup> and antibodies against any known agent have not yet been found. Diagnosis has been usefully based upon cold hemagglutination and streptococcal MG agglutination tests. Both these tests are frequently too limited, and none of the at least eight viruses<sup>15</sup> incriminated have been specifically verified. The etiology remains unknown.

Lymphocytic choriomeningitis is found in wild mice and excreted in mouse secretions. The disease often in man resembles gripe or mild influenza and diagnosis is made on isolation of virus from spinal fluid and blood inoculated into guinea pigs and mice.<sup>16</sup> Complement fixing and neutralizing antibodies are present and acute and convalescent serum samples must be used. Complement fixing antibody may disappear within weeks after onset while neutralizing antibody may last for several years.

Rabies is regarded as a uniformly fatal disease since there does not exist one proved instance of human recovery from an established infection. Serological methods are very useful for the diagnosis of rabies in that the neutralization and

complement fixation tests are readily applicable,<sup>17</sup> and paralysis following rabies vaccination if due to virus may be identified by serological and immunological means. Strains of street virus or fixed rabies virus vary<sup>18</sup> either in antigenicity, in the type of infection produced, or ability to form Negri bodies. The virus has been grown in the chick embryo and in tissue cultures.

Herpes simplex in man does not always exist in perfect symbiotic relation,<sup>19</sup> and when frank disease results, the diagnosis depends upon the isolation of virus, and the serological response of the patient. Any or all of the clinical entities<sup>20, 21</sup> may be due to primary herpetic infection, and this can be demonstrated by the development of antibodies against herpes virus during recovery. Recurrent herpes with local lesions and little systemic reaction is common. The meningoencephalitis of herpes has been reported only as a primary infection, and the diagnosis depends upon the demonstration of acute and convalescent antibodies to the virus. The virus of herpes simplex may be isolated<sup>22, 23</sup> from both primary and recurrent lesions by inoculation onto the chick chorioallantoic membrane, yolk sac, cornea of the rabbit, or cerebrally into rabbits, guinea pigs and mice. Serological procedures for identification require acute and convalescent sera for the neutralization test in mice, fertile egg yolk sac,<sup>24</sup> chorioallantoic membrane, and the complement fixation test.

Infectious mononucleosis at times presents meningeal, encephalitic and other neurological syndromes common to a number of virus or presumed virus infections. The etiological agent remains unknown but it is commonly placed in the category of virus diseases. Clinical and hematologic findings establish the disease. The blood serum and spinal fluid sheep cell titers in the acute phase and the rising convalescent serum titer should verify the presence of this infection. Sheep cell agglutinins in infectious mononucleosis are completely absorbed by beef red cells, but not greatly reduced by absorption with guinea pig kidney, and an artificial association has been recently demonstrated between infectious mononucleosis and Newcastle virus disease of fowl.<sup>25, 26</sup>

Measles virus is present in the blood and the most severe sequela is encephalomyelitis<sup>27</sup> in rare cases. Central nervous system involvement ap-

pear some days after the rash appears or after it has faded. The virus has been cultivated in tissue culture,<sup>28</sup> and by inoculation into the amnion or allantoic cavities as well as the chorioallantoic membrane of the chick.<sup>29</sup> This egg passage virus produces a greatly modified disease in monkeys and man, and no satisfactory serological techniques have appeared. Virus is present in blood and nasopharyngeal secretions up to 24 hours or so following the appearance of the rash.

German measles or rubella studied in Australia emphasizes the serious effect on the child of maternal infection during early pregnancy.<sup>30</sup> Microcephaly, deafness, mutism, microphthalmia and cardiac malformations have been found present at birth. Monkeys have been infected with blood and nasal washings taken 12 hours after the rash appeared. The virus has been maintained on the chick chorioallantoic membrane and found infectious for monkeys.<sup>32</sup> Laboratory diagnosis by serological procedures are not yet available. Rubella virus stored at  $-70^{\circ}$  C. for 9 months from blood and nasopharyngeal washings remains active. This material produced rubella with or without rash in humans, and rubella without rash was due to the same agent as shown by reinoculation. Monkeys, tissue cultures and chick embryos are not susceptible to the virus.<sup>33</sup>

The Cocksackie viruses,<sup>34</sup> or C viruses, first isolated in Cocksackie Village, New York in 1948, have been isolated from throat washings and feces taken from paralyzed and non-paralyzed children and adults.<sup>35</sup> These viruses have been incriminated in epidemic pleurodynia, aseptic meningitis and fever of unknown origin, and have been found in blood and spinal fluid. The type of illness is varied, and the role in human disease is not clear.<sup>36</sup> Cocksackie and poliomyelitis virus may be found present in stools as well as in sewage, and flies may carry both. The Cocksackie viruses are pathogenic for suckling mice and hamsters, and classified as A or B types depending upon simple histologic examination. Group A viruses cause widespread degeneration of striated muscle, and the mice die following flaccid paralysis, while group B viruses have focal muscle lesions with severe lesions of the brain and fat pads, the mice exhibiting spasms and paralysis. Both Cocksackie and poliomyelitis

antibodies identified by complement fixation and neutralization tests may be present in the acute phase and show rise of titer together within 30 days. The virus is not pathogenic for monkeys, chimpanzees or the fertile egg. Viremia has been proved for both Cocksackie and poliomyelitis by tissue culture tube methods. Cocksackie viruses can be cultivated in human kidney, brain and intestinal tissues, but unlike poliomyelitis do not grow in cultures of human embryonic skin-muscle tissue. A third group of viruses, also found in stools and called Q viruses, produce the tissue culture cytopathogenic effect.<sup>37</sup> They are not neutralized by poliomyelitis immune serum, but are neutralized by the convalescent patients' neutralizing antibody. These Q (query) strains are negative for monkeys or suckling mice, and after a few passages in tissue culture several of these Q strains have been found pathogenic for suckling mice, and to behave like Cocksackie viruses. All the strains to-date do not produce disease in monkeys or adult mice.

There is a miscellaneous group of viruses which infect man and are neurotropic in experimental animals. These viruses have been found in humans and mosquitoes in South America<sup>38</sup> and East Africa.<sup>39</sup> They have been regionally labelled Ilheus, Mengo, Semliki Forest, Bwamba fever and include the group of encephalomyocarditis<sup>40</sup> viruses. Incriminated more or less on serological evidence (neutralizing antibodies) or by virus isolation, occasional strains may be capable of causing encephalitis in man (Mengo). Dengue virus may cause meningeal and encephalitic signs in humans. The virus can be recovered from blood by intracerebral mouse passage or chick embryos. Complement fixation and neutralization tests are available. Hemagglutination tests for presence of virus can be used under limited conditions.<sup>41</sup>

Man is a more or less accidental host for the arthropod-borne neurotropic viral encephalitides. This group of viruses includes Western, Eastern, Venezuelan equine encephalitis, St. Louis, Hammon-Reeves California virus, and Japanese B encephalitis, as well as Russian Spring-Summer encephalitis and Louping ill. The viruses are not identical although similarities exist in the clinical and pathological picture of the encephalitis occurring in man. When isolated from central nervous system tissues all these viruses

are pathogenic for white mice and fertile eggs, and can be identified by serological and immunological means. These viruses may be found in blood, some appear rarely in the spinal fluid, and clinically inapparent infections have repeatedly been detected. Acute and convalescent sera from non-fatal cases are tested by complement fixation and neutralization tests against suspected viruses in order to show a rise of antibody titer for diagnosis.<sup>42</sup> Serological overlapping exists between Japanese B, St. Louis, West Nile and certain reputed strains of Epidemic keratoconjunctivitis virus.<sup>43</sup> Western, Eastern and Venezuelan equine encephalitis viruses sometimes show complement fixing crossing. Acute sera should be taken as early as possible, since neutralizing and complement fixing antibodies may be present on the 7th day of disease persisting for many months. The diagnosis of viral encephalitis can only be made by isolation and identification of the virus from blood, spinal fluid, nervous tissue, or by demonstrating increased specific viral antibody following infection. Hemagglutination is not at present suitable for diagnosis.

A revolution in the laboratory diagnosis of poliomyelitis, once surrounded by costly barriers, has made available specific diagnosis by isolation and identification of the virus. The viruses of poliomyelitis, Coxsackie viruses, along with other unknown fecal viruses, at present called Q viruses, can be grown in roller tube tissue cultures,<sup>44</sup> of skin, intestines, testes, and brain of human embryos, as well as in tube tissue cultures, and even in bottles.<sup>45</sup> A stable strain of human epithelial cells readily maintained and cultivated in vitro has been found to possess better properties for poliomyelitis virus growth than does monkey testes or other human tissues. Viability is maintained more easily for explants or virus inoculation. Roller tubes are therefore not necessary since the cells respond rapidly to support poliomyelitis virus growth. It has been solidly established in man, monkey and chimpanzee that a viremia occurs.<sup>46</sup> Virus has been isolated from blood, feces and central nervous system by this method. At least three distinct serological and immunological strains of poliomyelitis virus exist, and these collected from all categories of polio infection have been identified by the various tube tissue culture cytopathogenic techniques.

Virus in the past has been recovered from man by transmission to monkeys and chimpanzees, and a number of pathogenically variable strains were so isolated. The Leon, Lansing, Brunhilde and other strains have now been systematically classified as to character of antigen. Direct human to rodent transfer of poliomyelitis viruses has been mainly done only with the Type 2 strains known as the Lansing type, which include MEF<sub>1</sub> and other strains. Recent reports<sup>47</sup> claim successful Type 1 and Type 3 passage of poliomyelitis virus to mice, so that all three types now have been mouse adapted. Lansing type virus has been grown in chick embryos and a similar strain (MEF<sub>1</sub>) adapted to infant mice. The tissue tube culture technic has therefore provided a source of antigen for the known types of poliomyelitis virus, and fairly rapid identification<sup>48</sup> of virus types from stools, thus allowing complement fixation and tissue tube culture neutralization techniques to aid in identification of poliomyelitis from feces, blood, and throat washings.

Unfortunately, a disease occurring in mice spontaneously or after an inoculation has been mistaken for a Lansing type poliomyelitis. This latent encephalomyelitis (TO)<sup>49</sup> and its variants GDVII, FA and JHM are serologically distinct from polio but have some common properties. There also exist several rodent adapted strains of polio which do not conform.

#### SUMMARY

Recent advances in virus identification are based upon serological, immunological and tissue culture developments, or to quote Enders<sup>50</sup> in his address to the Association of Immunologists, "From these old fields new crops grow."

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# The History of Dermatology in Illinois

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It is appropriate that the first paper of the first meeting of the Section of Dermatology of the Illinois State Medical Society should deal with the History of Dermatology in Illinois. For it is only as we become acquainted with the enormous labor and hardships of the pioneers in dermatology that we realize how much we owe them. The writing of this paper was an easy task due to the excellent available material on the subject. Much what I have to tell you I have taken liberally from the excellent papers of Paul Bechet<sup>1</sup>, the late Max Wien<sup>2</sup>, J. M. McCuskey<sup>3</sup>, and Herbert Rattner<sup>4</sup>.

According to Paul E. Bechet<sup>1</sup> scientific dermatology began on November 27, 1801 when the old St. Louis Hospital in Paris was officially dedicated to the treatment of skin diseases with Jean Louis Alibert as its chief. Alibert and his disciples Bielt, Cazenave, Devergie and Bazin were also the teachers of the first American dermatologists.

American dermatology began in New York City on June 22, 1836 when the Broome Street Infirmary for Diseases of the Skin was opened under the direction of Dr. Henry D. Bulkley. Dr. Bulkley was also the first American physician to lecture on dermatology, first at his Broome Street Clinic and later at the College of Physicians and Surgeons in New York. He was also the first American to limit his practice exclusively to dermatology.

The second great event in American dermatology took place in 1845 when Noah Worcester published the first American textbook on dermatology.

Worcester was an extraordinary man of genius. In his brief life (1812-1847) he obtained an M.D. degree in 1838 from Dartmouth, studied pathology and dermatology in Paris, was professor of pathology at Western Reserve University in Cleveland, published his textbook on dermatology and was considered the best internist of his day.

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**Paper read at the 113th annual meeting of the Illinois State Medical Society, May 20, 1953.**

The third great event occurred in 1876 when the American Dermatological Association was founded, and there among the founders of the society we find the name of James N. Hyde, the pioneer Illinois dermatologist. In 1873 he began his teaching of dermatology at Rush Medical College. When you will recall that Harvard University established its department of dermatology only in 1871 then you will realize that Illinois was in the forefront of dermatologic progress.

In the history of medicine in Illinois, Rush Medical College played a great role. Established in 1843 when the population of Chicago was only about 5,000 it always attracted to its faculty men of ability, vision and leadership. In the course of its existence (1843 to 1940) it gave to American medicine many men of national and international fame and reputation. James Nevins Hyde began his lectures on skin at Rush in 1873 and became full professor of dermatology in 1879. He was chairman of the department from 1879 to 1910. Great men usually have the ability to choose brilliant associates. This was also true of Hyde. He surrounded himself with a group of men who became the leading dermatologists not only in Chicago but in the entire nation. These men, Drs. Frank Hugh Montgomery, Ernest McEwen, William A. Quinn, H. G. Anthony, Howard T. Rickets and Oliver S. Ormsby, made Rush a great center of dermatologic teaching and training. When Dr. Ormsby succeeded Dr. Hyde as head of the department, he, too, selected a brilliant group of men who established Rush as a great center for dermatologic teaching. These men, Edward Allen Oliver, James Herbert Mitchell, Clark W. Finnerud, Michael H. Ebert, Reuben Nomland are among our contemporary leaders of American dermatology.

Thus from 1873 to 1940 Rush Medical College had only two department chairmen, Drs. Hyde and Ormsby and a continuous single policy of teaching and research. Dr. Hyde published his textbook on Skin Diseases in

1883 and it underwent eight complete revisions and Dr. Ormsby's excellent textbook on Diseases of the Skin is now in its seventh completely revised edition with 683 figures, 764 illustrations, 18 colored illustrations, 11 plates, 1461 pages and is without doubt the most complete single volume on dermatology.

Northwestern University Medical School was organized in 1859 (Pop. of Chgo. 112,162). The first Professor of Dermatology was Dr. James Nevins Hyde. He continued to be professor at Rush and at Rush and at Northwestern University for two years. From 1878 to 1887 Dr. A. G. Paine was lecturer in dermatology followed by Dr. R. W. Bishop who was appointed Professor for one year 1887-1888. From 1888 to 1890 there was no professor of dermatology. In 1890 Dr. Joseph Zeisler was appointed Professor of Dermatology. He held this position with distinction up to 1917 when he retired as Professor Emeritus. Dr. Frederick Gillette Harris, a brilliant student of Pusey was Professor of Dermatology from 1917 to 1919 when he died. From 1919 to 1940 Dr. Arthur W. Stillians was Professor and head of the department and has since been Professor Emeritus. From 1940 to 1950 Dr. Edward A. Oliver headed the department with distinction. The present chairman and Professor of Dermatology is Dr. Herbert Rattner. Other distinguished men of Northwestern University department of dermatology were Drs. Ernest Zeisler, Harry Hedge, Maurice Dorne and Cleveland White to mention a few.

The University of Illinois College of Medicine was organized in 1883 (Population of Chicago 503,185) as the College of Physicians and Surgeons. The first Professor of Dermatology was Dr. Henry J. Reynolds who continued in this capacity up to 1891. In 1893 Dr. William Allan Pusey became Chairman and Head of the Department. He held this position up to 1915 when he became Professor Emeritus. In 1924 Dr. Francis Senear became Professor and Head of the Department, a position which he still holds with great ability and success. Dr. Senear trained a large number of distinguished dermatologists: Drs. Max Wien, Leonard Weber, Herbert Rattner, Mark Caro, Theodore Cornbleet and many others.

The University of Chicago School of Medicine

was opened in 1942 and the department of medicine in 1927. The first Chief of the Department of Dermatology was Dr. Samuel W. Becker. Dr. Maximilian Obermayer and later Dr. Stephen Rothman were his associates. Since 1945 Dr. Stephen Rothman has been the Chief and Professor.

The Stritch School of Medicine of Loyola University began in 1916 with the purchase of Bennett Medical College and the Chicago College of Surgery. The first Chairman of the Department of Dermatology was Dr. Kasimir A. Zurawski who served in 1918. Drs. Edward A. Fischkin, Arthur W. Stillians and William A. Quinn were chairmen of the department for short periods. In 1924 Dr. Benjamin Barker Beeson was appointed as Professor and he served till 1945. Dr. Cleveland White is the present chairman.

Dr. Maurice Oppenheim was Chairman of the Department of Dermatology of the Chicago Medical School from 1940 to 1949 when he died.

A unifying force of dermatology in Chicago was and is the Chicago Dermatological Society. The society was organized in 1901. The charter members were Drs. James Nevins Hyde, William A. Pusey, Joseph Zeisler, William L. Baum, Frank Hugh Montgomery, L. Blake Baldwin, H. G. Anthony, Alfred Schalek and Lucius Crocker Pardee. The first officers were James Nevins Hyde, as President, Joseph Zeisler as Vice President, and Pardee as Secretary. Today the Chicago Dermatological Society has 53 active resident members, 40 active non-resident members, 45 associate members and two honorary retired members. Throughout its existence the Chicago Dermatological Society was guided by the principles of its founders to be the "cultivation of dermatology in all its branches, the edification of its individual members in their chosen specialty, and the cultivation of fraternal spirit among the members." For more than forty years the society was guided by three great leaders, Drs. Hyde, Ormsby and Pusey. These men were highly gifted and accomplished much for dermatology. They set the pattern for the society. Their contributions to dermatology were through textbooks, lectures and in organizations. They were Presidents of the Chicago Dermatological Society and of the A.D. A. Dr. Pusey was also President of the American

Medical Association. Pusey's pioneer work in x-ray and CO<sub>2</sub> snow is known to every dermatologist in the world. Almost every dermatologist in Chicago was a pupil and disciple of either Ormsby or Pusey. Pusey as the first Editor of the Archives of Dermatology and Syphilology made the Archives the foremost Dermatological Journal in the world.

I wish to add here the contributions to Chicago Dermatology made by immigrants from Europe and especially by Drs. Zeisler, Lieberthal, Obermayer, Oppenheim and Rothman. By bringing to us their continental training, culture and experience, they have enriched our knowledge and we are indebted to them.

Almost from the very beginning the Chicago Dermatological Society counted among its members outstanding dermatologists from outside the state. These men, Drs. Otto Foerster, Udo Wile, Paul O'Leary and his associates Harry Foerster, Arthur Curtis, Henry Michelson and his associates Richard Weiss of St Louis and many others. These members have contributed enormously to make the meetings of the Chicago Dermatological Society the best Post Graduate Forum in the country.

In 1950 a group of Chicago dermatologists organized the Metropolitan Dermatological Society of Chicago. The charter fellows of this Society were Drs. Tibor Benedek, Theodore K. Lawless, Irving M. Cobin and Harold W. Thatcher. The society meets once a month from October through May. The society has an annual Arthur Sillians Lectureship. The present officers of the Society are Drs. Rudolph S. Lackenbacher, President, Franz Baumann, Vice President, Tibor Benedek, Secretary. This is but a brief outline of Dermatology in Illinois. A detailed history would fill a book. If in this brief paper, I omitted any names, I wish to state that it was not done with any malice.

I shall conclude with the words of a wise and great Baltimore physician<sup>5</sup>. "An old book tells us that each generation may be looked upon as standing on the shoulders of its fathers. If our vision is clearer, our intellectual view less obstructed, our horizon broader, then it is in part due to the height to which others have given. Unmindful of this we are apt to exaggerate our own greatness and the importance of our work."

Let us, therefore, proceed to build this sec-

tion of dermatology on the solid foundation laid down for us by our great predecessors.

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#### DISCUSSION

John M. McCuskey, Peoria.—Historically speaking, 80 years is a comparatively short period of time but we must realize that almost all historical facts pertaining to our specialty have occurred in this period. It was in the year 1873 that the first department of dermatology was established in a medical school in Illinois. We can assume that when Dr. James Nevins Hyde began his lectures at Rush Medical College in this year our specialty was born in Illinois. We have just had the pleasure of hearing Dr. Zakon's interesting and informative presentation of historical facts relative the origin and development of dermatology in our state during this 80 year period.

In 1940 it was my pleasure to write on the history of dermatology in Illinois for the 100th Anniversary of the founding of the Illinois State Medical Society. We are apt to think, when we study history, that the really important events took place many years ago and be unaware that history is being made every day of every year. As George Wm. Curtis has said, "While we read history we make history". So I was somewhat surprised to find how our specialty has grown during the past 13 years despite the fact that World War II was fought and comparatively few men were trained in our specialty during this war period.

In 1940 the Chicago Dermatological Society had 33 active members, 21 associate members and 2 honorary members. Compare these figures with the membership today of 53 active, 40 active non-resident, 45 associate and 2 honorary retired members, making a total active, associate and honorary membership of 142 compared to 56 in 1940. In addition this society now has a guest list of 107.

Many of the members of the Chicago Dermatological Society reside and practice outside the state but the number of members practicing in Illinois has increased from 25 in 1940 to 64 in 1953. This is a considerable increase in membership in a 13 year period.

The increase in the number of dermatologists practicing in Illinois is proportionate to the increase in membership of the Chicago Dermatological Society. In 1940 were 36 members of the American Academy of Dermatology and Syphilology practicing in this state of Dermatology and Syphilology in our state has increased from 36 in 1940 to the present number of 80.

While these statistics all show the recent tremendous

increase in numbers of physicians practicing our specialty in Illinois it is much more difficult to evaluate increase in quality. This must be left for future historians. We must all admit that the physicians practicing our specialty in its early days of birth and development made contributions that will be difficult to equal. Certainly our specialty in the past 80 years has more than kept abreast of the development of medicine in general during this period and dermatologists in our

state have more than contributed their share towards this advancement. There has been great progress in the teaching of our specialty and in post-graduate training. The organization of a Section of Dermatology in our State Medical Society is but one example of this progress. Certainly, the combined interest and efforts of all of us should make this Section of Dermatology a worthwhile milestone in the history of dermatology in Illinois.

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### **EDEMA IN PREGNANCY**

The edema that usually is present in pregnancy is primarily a physiologic edema and is believed to be due to an increased sodium retention which holds water in the interstitial spaces. Apparently, this sodium retention in gravid women is secondary to an increase in sex steroids, chiefly estrogen. Evidence for this concept is the observation that the administration of estrogens results in sodium and water retention. Furthermore, the maximal development of physiologic edema of pregnancy corresponds with the peak levels of sex steroids characteristically seen during the latter part of

gestation. There is a spontaneous naturesis and diuresis which accompanies the rapid fall in steroid level following parturition, and this and water tide can be delayed by the administration of estrogens. These observations offer convincing evidence that the changes in sodium and water metabolism are apparently secondary to the estrogen saturation of pregnancy. It is probable that the pathologic edema associated with toxemia of pregnancy represents an exaggeration of the changes in water and sodium metabolism that are present in every gestation. Willis E. Brown, M.D., and G. G. Sutherland, M.D. *Control of Edema in Pregnancy*. GP, Nov. 1953.

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*Your Annual Meeting*

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# CASE RECORDS OF THE COOK COUNTY HOSPITAL

KARL MEYER, LEO M. ZIMMERMAN, DEPT. EDITORS

## Neck Injury Due to Ice Pick Stabbing

Joseph P. Cascino, M.D., Thomas W. Carter, M.D., and James J. Duffy, M.D.\*  
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We wish to present an interesting case of a neck injury with the possibility of severe spinal cord injury. Fortunately, the residual was confined to a minimum extent. From time to time, we have noted ice pick injuries at Cook County Hospital. The ice pick is invariably buried in some aspect of the neck and frequently there is spinal cord involvement. In our experiences, ice pick injuries of the spinal cord are usually cervical in location, and because they usually involve one-half of the spinal cord, a Brown-Sequard syndrome usually ensues. In this case, although we have a severe neck injury and the burying of an ice pick into aspects of the spinal column, the spinal cord was spared injury, both at the time of introduction of the object and at the time of retrieving. The case history follows.

The patient is a 22 year old, Negro girl who was admitted ambulatory to a general surgery ward on October 10, 1953. She was alert and lucid and stated that while she was with a girl friend, an argument developed and she was stabbed with an ice pick in the neck. Fol-

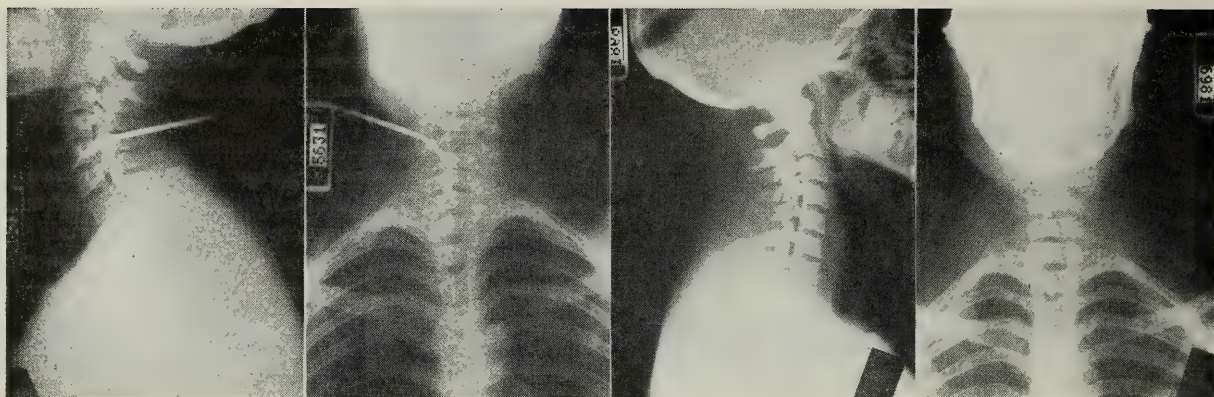
lowing the stabbing, the patient came to the hospital without assistance.

Physical examination revealed the pick extending 5cm. from the skin surface and located in the left mid-posterior portion of the neck 3cm. from the midline. Blood pressure was 125/85, pulse 96, and respirations 20. The remaining physical examination was essentially negative. There were no neurological abnormalities. Hemoglobin was 90% and urinalysis was negative. X-rays of the cervical spine revealed the pick to be directed towards the midline at approximately a 45° angle and to enter the 5th cervical vertebra at the base of the transverse process, and extending anteriorly into the mid-portion of the body of the 6th cervical vertebra. The intravertebral portion of the neck was bent inferiorly 30°.

Because of the proximity to the cervical spinal cord and its liability to damage, an open extraction and laminectomy was considered advisable and the patient was transferred to our neurosurgical service.

On October 16, 1953 a midline posterior longitudinal incision was made in the region of C3-C7. The pick was seen to lay between

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**Pre-operative**

**Post-operative**

the transverse processes of C5 and C6 and to enter the 6th cervical vertebra proper at the base of its transverse process. The pick was severed at the surface of the vertebra with large triple action wire cutters. The bone immediately adjacent to the pick was ronguered away thus exposing the dura mater which was found uninjured. Care was taken to avoid injury to the vertebral artery within the vertebral fora-

mina. A good hold was secured on the pick and it was removed without difficulty. Following this, the laminectomy was extended up to C5 and C4 to prevent cord damage from post-operative edema.

Recovery was uneventful and the patient was discharged the 7th post-operative day. No deficit was noted as to spinal cord or nerve root injury.

## **TREAT PULMONARY ABSCESES EARLY**

Pulmonary abscess is not a medical problem nor is it a surgical problem, but a combination of both. It is an unpredictable disease with ever present surgical possibilities and the best results are obtained by a physician and a thoracic surgeon working as a close team. Most clinicians believe that pulmonary abscess is a disease of aspiration rather than embolism. It has the characteristics of an abscess anywhere

in the body, in that cure is dependent upon adequate drainage. I am opposed to treating a lung abscess medically for one period of time and surgically for another. If the abscess is to be treated successfully, it should be treated during the acute phase by an integrated team. Within six weeks from onset, the optimum time for curative measures has passed and chronic pathological changes have already become established in the pulmonary parenchyma. *R. Adams Cowley, M.D., The Treatment of Pulmonary Abscess. Maryland M. J., Nov. 1953.*

## CASE REPORTS



# Fatal Thrombocytopenic Purpura Following Phenylbutazone (Butazolidin) Therapy

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Johannesburg, South Africa**

Since the recent introduction of phenylbutazone to clinical medicine, many toxic effects from it have been described in the medical literature. While some of these reactions were not very serious, as edema, nausea, anemia, reactivation of latent peptic ulcer, vertigo, and skin eruptions<sup>1, 2, 3</sup>; others were. Cases of agranulocytosis<sup>4, 5</sup> yielding to treatment, and one terminating fatally<sup>6</sup> have been reported. Non-fatal thrombocytopenia as a complication has been reported in 16% of 188 patients studied<sup>7</sup>. In some of these the platelet counts dropped to as low as 30,000 per cubic millimeter. We are reporting a case of fatal thrombocytopenic purpura from the use of phenylbutazone.

A 61 year old woman was first seen in the office on March 7, 1953. She was sent in by her family physician for an opinion, because of bleeding from the mouth, dark stools and purpuric spots on the legs and trunk of seven days' duration. She was in Florida at that time and refused to be hospitalized there; waited a week and finally flew home.

She had been in good health and free from any allergy. A few years ago she began having pains in various joints, and about one year ago she had an operation on her left hip. Five months ago she was started on yellow pills (Phenylbutazone) by an orthopedic surgeon and these gave her a good measure of relief. She was advised by the surgeon that frequent blood counts were essential while she took this drug but the patient stated that she kept on taking the drug and returned only once for a blood count, about three months prior to her present complaints. A check

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with the druggist revealed that the various refills between November 24 and February 26, 1953, amounted to a total of 140 tablets, 200 mg. each of phenylbutazone.

On physical examination, the patient appeared comfortable, walked in with a cane, and did not appear pale. Blood tinged saliva was escaping from her mouth, necessitating her using kleenex tissue very frequently. Pulse rate was 84, regular, blood pressure 130/80, temperature was normal and so was the respiration. There was no adenopathy and the breasts were not abnormal. Examination of the mouth revealed a cherry sized clot on the hard palate and the buccal mucosa of each cheek. There was some bleeding from the gums. Examination of the heart and lungs showed no abnormalities. The liver and spleen were not palpable. Numerous petechiae and ecchymotic spots were noted all over the body. Neurologic examination revealed no abnormalities. The fundi were normal. Laboratory studies revealed RBC 3,180,000, Hb. 9.6 gm. (61.5%), WBC 3000, Hematocrit 28 and platelets markedly reduced. The differential count was: Segmented granulocytes 47, Lymphocytes 45, Monocytes 7, Clotting time 18½ minutes. Bleeding time was more than 10 minutes. The urine showed many red cells. The stool was strongly positive to benzidine.

The patient was hospitalized immediately. Blood transfusion was started and ACTH was given. During the night she developed a severe headache and vomited dark, blood-stained material. Two hours later she was in stupor, and the Babinski response was elicited bilaterally. Coma deepened and the patient expired at 9:30 A.M. on March 8, 1953.

Necropsy by H. Hirsch of the department of pathology.

Gross and microscopic findings: *Lungs*: hemorrhages, interstitial; focal hemorrhagic necrosis and edema. *Heart*: Hemorrhages; interstitial; focal fibrosis. *Thyroid*: Adenoma; interstitial hemorrhages. *Brain*: Meningeal hemorrhage,

subarachnoid. *Cerebrum*: Interstitial hemorrhage. *Cerebellum*: Hemorrhage diffuse with necrosis. *Stomach*: *Small Intestine and Colon*: Hemorrhage, interstitial and mucosal. *Skin*: Purpura. *Pituitary*: Hemorrhage focal. *Aorta*: Hemorrhage adventitial. *Urinary Bladder*: Hemorrhage, mucosal. *Liver and Spleen*: Acute passive congestion. *Bone Marrow*: Hypoplasia. *Lymph Node*: Hemorrhage, interstitial.

*Clinico-pathologic correlation*: The hemorrhage noted during life was also observed in the internal organs as mentioned. The large intracerebellar hemorrhage was probably the immediate cause of death. The purpuric state most likely originated in a sensitization to the drug taken — Phenylbutazone (Butazolidin).

#### SUMMARY

A 61 year old woman who ingested approximately 140 tablets of Phenylbutazone, 200 mg. each, during a period of 12-14 weeks, developed a fatal thrombocytopenia. The clinico-pathologic correlation points to the drug as being responsible for this fatality, since there was no other obvious cause for the purpuric state.

To our knowledge this is the first case report of fatal thrombocytopenia resulting from the use of this drug.

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## EDITORIALS



### IS ICE SANITARY?

Since the turn of the century, the consumption of ice has increased manifold. Ice cubes and crushed ice have been introduced into beverages and are used to chill foods, some of which are raw. The practice presents a sanitary problem because there are many possibilities for contamination, especially when the ice is handled on a commercial level.

A recent study was made on ice samples collected from hotels, restaurants, soda fountains, hospitals, and soft drink parlors in central Kansas. Included were specimens from ice cube machines and crushed ice; collections were made in June, July, August, and again in December and January, using standard bacteriological precautions and methods to prevent contamination. The survey revealed that only 23 per cent of the samples were free from a coliform contamination that would be acceptable in terms of drinking water standards. Summer samples contained the highest average bacterial count, indicating an inferior quality of ice. Ten per cent of the commercially crushed ice and 46 per cent of the cubed ice specimens were free of bacteria, demonstrating the purity of the latter. All hospital samples were free of such organisms.

The ice was allowed to melt. The sediment, studied under the microscope, was found to "contain sand, clay, assorted colored fibers, as-

sorted colored threads, vegetable fibers, finger nail polish scales, insect fragments, rodent hairs, and wood splinters." The ice cube samples contained the least amount and the summer specimens, the largest. Bacterial studies for other organisms revealed that the majority of ice samples also contained clostridia, enteric bacilli, micrococci, and streptococci. These organisms generally have been associated with food poisoning.

The sanitary condition of ice depends upon the water supply, the cleanliness of the freezing machines, and the care with which the ice is handled. Cake ice contains few organisms whereas crushed ice may be loaded, suggesting that bacteria gain entrance, at one or more points, between the freezer and the consumer. This may occur in the plant itself or in the sawing, crushing, or grinding equipment. The containers in which ice is transported also are open to question as well as the loading and unloading docks, delivery trucks, and the insulating blankets. The dispensing facilities may be the culprits, as many producers now deliver crushed ice in bags.

There are many regulations covering sanitation of ice plants. Regulated cubing and shaving machine are coming into vogue. In Chicago, when contaminated samples are discovered, the ice is immediately labeled, "Not fit for human

consumption," and turned over for use in refrigerator cars or for other storage purposes. In this respect, the ice companies co-operate wholeheartedly because there always is a use for the ice produced.

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## THE HEALTH RECORD FOR 1953

According to statisticians of the Metropolitan Life Insurance Company, the health records of the people of the United States were excellent during 1953. The estimated death rate for the nation in 1953 was 9.6, or approximately the same as for the preceding year. This too was the sixth consecutive year in which the death rate in this country was below 10 per 1,000. This rate continued low in spite of the outbreak of respiratory disease early in 1953, and a severe heat wave in the summer, which took their toll especially among people with chronic disease.

The death rate from tuberculosis was under 13 per 100,000 population, which is perhaps a decline of one fourth from the preceding year. It was stated that this rate from tuberculosis is approximately one half of that of 1949, and ten years ago it was three times as high. Infant mortality was at a new low, being estimated at 28 per 1000 live births, and the maternal mortality was reduced to less than 6 per 1000 live births. It was stated that during the past five years alone maternal mortality was reduced 50%, and about 75% in the last 10 years.

Poliomyelitis, with 36,000 cases reported during 1953, showed a decline of approximately 40% over the preceding year, and case fatality has likewise been declining. The death rate for 1953 was about one per 100,000 population. A small increase was noted in mortality from chronic diseases of the heart, kidneys, arteries and from cancer. This increase is most likely due principally to the ever increasing number of older persons in the country. The diabetes death rate was approximately the same as for the previous year. A slight improvement in the control of accidents during 1953, even though there is a continued increase in the number of cars and in total automobile mileage. A slight decrease was noted in the occupational accidents during the year. The prospects seem good for betterment of the nation's health through the

reduction of preventable diseases and accidents, and the control of degenerative disease. The statisticians believe that the favorable health record for 1953 can be attributed in large part to the steady gains and great efficiency of medical and public health services, to research in these fields, and to the high standards of living of the people of the United States. Even though with unstable world conditions, with large forces overseas, many in combat areas, or other places with poor sanitary facilities, diseases common in these countries have not been brought into the United States, which speaks well for the services of the medical staffs of the armed forces. For further gains against tuberculosis, and perhaps some other diseases, more efforts must be exerted to reduce the mortality from the chronic, degenerative diseases, and reduce the loss of life from motor and industrial accidents. The public no doubt will support efforts to materially reduce the accident death toll especially from motor vehicle accidents, and support improved programs of highway safety and public education.

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## SERVICES OF THE DIVISION OF VOCATIONAL REHABILITATION\*

I. What we CAN DO is to provide for the handicapped an opportunity for job preparation equal to that which the public-education program provides for the non-handicapped. The four services listed below are available to *vocationally* disabled persons *regardless of ability to pay*:

1. Complete diagnostic service — medical examinations; specialist and clinical study; psychiatric study; psychological testing.

2. Guidance based on diagnosis and case study.

3. Training tuition.

4. Placement and follow-up.

If one is *not* financially able to provide them, these services are available:

5. Medical, surgical, hospital, and psychiatric service, occupational and physical therapy, if diagnosis indicates cure or substantial improvement in a reasonable length of time. (See II, 4 below).

6. Artificial appliances.

7. Training supplies.

8. Maintenance and travel during training. *Not* public assistance; covers only increased ex-

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\*700 East Adams, Springfield, Illinois.

pense resulting from our rehabilitation plan.

9. Occupational tools and equipment for use in a trade or business.

II. What we CAN NOT DO — criteria for eligibility.

1. *Employability.* We can not provide any services merely because one is disabled; there must be a substantial vocational handicap and reasonable expectancy that our service will result in employment.

2. *Economic Need.* We can not provide services 5 to 9 above unless there is proof of client's inability to pay.

3. *Duplication.* We can not provide services elsewhere available; e.g., 4d.

4. *Physical restoration limitations.*

a. *Acute disabilities.* We can not treat acute temporary disabilities such as appendicitis or pneumonia, since they are not a vocational handicap.

b. *Chronic disabilities.*

(1) We can not treat chronic disabilities such as tuberculosis, since they are primarily medical problems, since there is no reasonable expectancy of a job until after the disease is arrested, and since we are limited by statute in this field.

(2) We can not render vocational services until the chronic ailment is diagnosed as slowly progressive, arrested, or likely to be arrested in a reasonable time.

(3) We can not render any service if chronic disability is such that employment is impossible.

c. Any *disability*: We can not treat any disability unless diagnosis indicates the probability of cure or substantial improvement through medical care within a reasonable length of time and with no more than 90 days of hospitalization.

d. Those under 21 secure *physical restoration* services from Illinois Division of Services for Crippled Children.

## NEW MEDICAL RESEARCH BUILDING AT NORTHWESTERN

Construction of a seven-story medical research building will begin in February on Northwestern University's Chicago campus, it was announced by Dr. J. Roscoe Miller, University president and Dr. Richard H. Young, dean of the Medical School.

The addition to Northwestern's medical school will be known as the Morton Medical Research



Morton Medical Research Building

building. It is the first new medical building to be erected by the University since the Montgomery Ward Memorial building, which also houses the Northwestern dental school, was completed in 1926.

The Morton building, scheduled for completion in May, 1955, will be occupied by research personnel who previously have carried on their work in the laboratories of the Ward building at 303 E. Chicago ave.

The Morton building, to be located at 310 E. Superior st., will be financed by a \$2 million bequest left to the University by Mrs. Margaret Gray Morton, who died in 1940. Mrs. Morton was the widow of Joy Morton, Chicago financier and founder of the Morton Salt Company.

The building, to be erected just south of the Ward building, will be built in a T-shape. Its vertical axis of 77 feet will be connected with a wing of the Ward building to the north and the horizontal axis of 93 feet will front on Superior st. There will be 40,000 square feet of floor space.

Of modified Gothic architecture, similar to the Ward building, the new structure will be faced with Indiana limestone. It was designed by Holabird & Root & Burgee, Chicago, to permit maximum flexibility for any size or type of research.

A special feature of the construction will be movable metal wall partitions which can be set

up at any 10-foot interval within the building. This will enable research people to convert laboratories at a moment's notice to almost any size desired. Each movable wall will be equipped with water, gas, steam, air, and vacuum pipes.

Fourteen specially designed chemical hoods will be built for experiments with noxious fumes. A roof fan, which will exert a uniform pull on the hoods whether one or all are turned on, will have a drawing capacity of 11,200 cubic feet of air per minute.

An electrical power supply of 576,000 watts will be conducted in a bus duct system unusual in a research building. A continuous run of copper bars for conducting electricity will be constructed in all corridors of the building. Switches can be attached at any 1-foot interval along the bars to provide power at almost any point in the building.

Contractors will be announced after bids are received on Jan. 15.

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## **UNIFORM DEFINITIONS OF MOTOR VEHICLE ACCIDENTS**

The second revision of the Uniform Definitions of Motor Vehicle Accidents, the first since 1947, has just been issued by the Public Health Service of the Department of Health, Education, and Welfare. Used principally by personnel in vital statistics and motor-vehicle accident records bureaus, the manual was revised in order to be a more useful guide for such offices as well as traffic agencies, insurance companies, and other groups which compile figures on motor-vehicle accidents.

The definitions in the manual were formulated for the National Conference on Uniform Traffic Accident Statistics by a committee under the chairmanship of Dr. Halbert L. Dunn, Chief of the Public Health Service's National Office of Vital Statistics. The manual is an important reference for assuring uniformity and comparability in classifying information from traffic accident investigators' and drivers' reports, cor-

oners' and medical examiners' records, and death certificates. It is also used in training courses for traffic officers.

Changes made in the revised manual include a new definition of injury and an appendix defining characteristics of the location of the accident. Injury was redefined to allow rough classification at the scene of the accident. The definition allows for three gradations, with objective signs like a bleeding wound or distorted limb; other visible injuries such as swelling, abrasions, or limping; and complaint of pain without visible signs of injury. These gradations were developed because the previous criterion, need for medical attention within 6 to 12 months of the accident, had proved impractical, because of difficulties in followup by traffic accident records bureaus, difference of interpretation, and in accessibility of hospital and physician records.

A paragraph was added to the section on allocation of motor-vehicle accidents according to geographic boundaries. It provides that "motor-vehicle accidents on trafficways administered by independent agencies such as turnpike, parkway, military, or freeway authorities or commissions may be classified in a separate category from accidents on other trafficways in a geographic area, but they shall be shown in the total for the area (city, State, county, etc.)." No changes were made at this time in the definition of a motor-vehicle accident fatality, and in other respects the manual closely resembles the previous edition.

The National Office of Vital Statistics will send a copy of the manual to vital statistics offices of the major cities and each State as well as to all traffic agencies. Representatives of each of the twenty-five organizations that make up the National Conference on Uniform Traffic Accident Statistics will receive copies from the Secretary of the Conference, Mr. David M. Baldwin, c/o National Safety Council, 425 N. Michigan Avenue, Chicago 11, Illinois. Others requiring copies may obtain them from Mr. Baldwin.

# MEDICAL ECONOMICS

**The Medical Economics Committee. John R. Wolff, Chairman, Walter C. Bornemeier, Edward W. Cannady, Roland R. Cross, Jr., E. F. Dietrich, W. W. Fullerton, Edwin F. Hirsch, Frederic T. Jung, W. R. Malony, Caesar Portes, William Requarth, Frederick W. Slobe.**



## The House Staff Problem

**Roland R. Cross, Jr., M.D.  
Chicago**

Back in the thirties, life was well arranged, well ordered, and peaceful. Now it seems that every aspect of life is upset, one of which is the house staff problem. During the war there was a shortage — immediately after the war there was a surplus. This created a rush as hospitals tried to become approved for interns and residents. To be so approved seemed to be an accolade of accomplishment. Now again we have more approved positions than we have young graduates.

At the same time the medical family has another problem about which much has been said and written. This is the problem of the General Practitioner — the rush of the young physician into the specialty field. And this brings up to some extent the problem of the failure of physicians to go into semi-rural communities (and I say semi-rural for that is what it really is today with our excellent means of transportation).

Now it seems to me that these two problems have something in common which might help in their solution.

The great specialists of the past decade did not become so overnight — nor over a period of

one or two years. For the most part they started out as “physicians and surgeons” in the broad aspect. As they became interested in certain aspects and so became better informed, they became recognized by their fellow physicians as specialists to whom they were glad to turn in time of need for added consultation and opinion. To some extent the present day residency training is a shortcut on the part of the younger man to attain the respect his elders had gained by a more solid but slower growth and maturation.

And so today we hear frequently the criticism that the specialists are too narrow. It is said they do not see the whole patient — either his whole self alone or his whole self as it fits into its family and position — that the specialist in treating a stomach ulcer may miss the prostate or vice versa.

The thought is not new, but neither is it in general discussion, that these young people are not really acquainted with general medicine. They are exposed to four years of medical training at the hands of specialists from the time they enter medical school to be taught by a specialist in anatomy to when they leave after being taught

by an internist who specializes in cardiology.

Some states have inaugurated a program of putting the young student out in the smaller communities as an assistant for a short period to some especially interested general practitioner. This requires time away from school and the schools are finding it harder and harder to find any time to let them go. Even now the medical schools in an attempt to crowd more into the curriculum are having the students continue in school rather than give them the time honored three months summer vacation between the junior and senior year.

Now it has been suggested meekly and faintly that the medical schools should cease having internships in the university affiliated hospitals. After all, they have the junior clerkships, the senior clerkships, the large groups of residents (junior, intermediate, and senior), and also a varying number of fellows.

There are five medical schools in the State of Illinois, and they have eleven affiliated hospitals. These eleven hospitals are approved, according to the Journal of the American Medical Association, Sept. 27, 1952, on approved internships and residencies, for a total of 375 internships. This does not include residencies. There are a total of 789 approved internships in Illinois hospitals. If the university affiliated hospitals ceased to have interns, it would almost double the number of available young physicians.

These young people would then have to intern in the general type hospital — which, after all, supplies the major portion of medical care. They would see medicine as it is practiced. They would see general medicine — for the first time. They would probably actually get to do more. They would really get their feet wet. They

would see sick patients that were diagnostic problems — and not see a large group that have been carefully screened by some clinic before being admitted to the beds upstairs or if they were diagnostic problems, they were so because some specialist was interested in Tsutsugamuchi fever and he had a possible case in for study.

If, after this broader experience, they wanted a residency, they could then specialize by building on a broader base.

One frequently hears a senior say the only reason he is taking an internship in the university hospital is to become acquainted with a certain specialist in order to get his recommendation. This is a compliment to the young man for thinking ahead but if there were no university hospital internships, then all the prospective interns could be equal in applying for the same residency. Instead the intern in the more general hospital has, to some extent, to compete with the personal acquaintanceship acquired by the university hospital intern.

In order to produce a change of this order, there will have to be a grass roots feeling on the part of the great mass of members of the American Medical Association. This conviction would then be felt by the officials of the American Medical Association and the committee that formulates the rules regarding internships and interns. Medical schools cannot be expected to initiate such a program although I have heard one dean state that it was a good idea. But it would be a good idea for the young physician, for he would learn to know medicine in Moline, Springfield, Rockford, Peoria, Decatur, and the rest of Illinois away from the cloisters and study halls (and be out in life).

# THE P.R. PAGE



## Busy P.R. Year Ahead

The president's various messages to Congress in early January and the bills already presented in both houses presage a year of activity for those responsible for the public relations of organized medicine.

Let us perfect our organization and define our aims and methods *now*, so that, when the pressure comes on, we will be ready to act. Remember, too, that there is a primary election in April and a general election in the fall. To be elected are a senator, all congressmen, and most of the Legislature — all of them essential to the welfare of public and medical profession.

How many physicians know about the senatorial committees, those mysterious groups peculiar to Illinois General Assembly elections? That their only function is to decide how many candidates their party will put up for state representative? And that, they have now made their intraparty deals, and in many districts, maybe 40 or 50% of the State's 51, they have decided to have only three candidates for the lower house from both parties? And that, therefore, as much as half of the personnel of the House will have been decided, *without a popular vote*, by the time you read this?

Now is the time to think about organizing political action committees to give expression to your opinion on the records of candidates of whatever party. Need any help?

## The Current Socialist Line — So You will Recognize It

"In the present period, every socialist must take up the scattered symptoms of decline in the economy and discuss them with his co-workers. Those individuals who can be brought to understand that the economic decline which is under way is not accidental, but is an expression of the deeper bankruptcy of capitalism are well on the road to becoming socialists."

And,

"Every capitalist nation has repeatedly sought a new lease of life in war, and American capitalism has been no exception. When one further considers that such a counter-revolutionary war as Wall Street now contemplates expresses the deepest political desires of U. S. capitalists, then one can plainly see how great the war danger is and will become."

—The American Socialist, January 1954.

## P.R. Pamphlet's Fame Spreads

The public relations pamphlet for county medical societies published recently by the Committee on Medical Service of the Illinois State Medical Society was distributed to medical societies throughout the country last month in the P. R. Doctor, the American Medical Association's exchange service. Requests for copies began to come in immediately, with the Montana

State Medical Society first in line asking for twenty-eight copies.

Practically all the larger downstate county medical societies in Illinois have now registered the names of their public relations chairmen and asked for additional copies of the pamphlet.

The committee hopes to hold another public relations dinner this year during the annual meeting in May. The program is already in the gestation stage -- and it is the committee's purpose to interest every county public relations chairman to attend.

Please let the committee have the name of your P. R. chairman, or other P. R. representative, and send in the postcard if you want any number of additional copies of the P. R. Textbook. 185N. Wabash Avenue, Chicago 1.

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### **Newspaperman's Opinion**

"A common impediment to satisfactory press relations is the too prevalent tendency of the layman to assume that he knows as much or more about what is news and how it should be written than the fellow who makes his living by these skills. The average reader of daily newspapers, even though he be an observing person, falls lamentably short of the mark when he undertakes to do a piece according to his own ideas of journalese .....

"Remember, too, that your own little contribution to current history may not be as important to the general public as it seems to you."

L. E. Judd in "Your Public Relations."

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### **Winnebago Society's Blood Bank**

The blood bank established under the aegis of the Winnebago County Medical Society has just ended a successful first year. It has repaid 20% of the loan made to it by the society. All other debts are paid and the bank is fully solvent. It employs four full time and two part

time personnel. About 7,500 Rockford families have joined it. A new membership drive is being conducted, with the ultimate aim of getting every family in the Rockford area to become members.

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### **Remember The Fair**

County fairs are extremely valuable channels to the public mind. Now is the time to begin planning a county society exhibit. If you want help or suggestions, this committee is ready and willing to fill all requests.

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### **New A.M.A. Exhibit Catalogue**

The A. M. A.'s Bureau of Exhibits has just published a new catalogue of its striking exhibits on health -- with pictures.

The exhibits are available for use on loan at county and state fairs. The demand will be heavy and requests for reservations should be made early.

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### **Dr. Keefer's Advice:**

"In its interim report, your Committee on Medicine in the Changing Order said that efforts to cure the world of its ills by 'massive' doses of social legislation were fraught with great danger. I subscribe to that opinion. The medical profession, however, cannot solve the public health problems of the day by ignoring them. Only by listening to the patients' description of his aches and pains and by sympathetic understanding of the reasons for the emotional, social, and economic symptoms of which he complains can the doctor help the patient find and pursue his own way to recovery."

Chester S. Keefer, M.D.

Special Assistant to the Secretary  
for Health and Medical Affairs

—Address before the N. Y. Academy  
of Medicine Jan. 7, 1954.

# KNOW YOUR SOCIETY



## COUNCIL COMMITTEES (Continued)

*Committee on Mental Health.* The field of mental health has grown in importance, both as a subject discussed in detail by the laity, and as a subject worthy of serious consideration and thought by all members of the medical profession. This Committee has cooperated with the State Department of Public Welfare, and (since the chairman is also a member of the Mental Health Advisory Committee for the State Department) he has represented the Illinois State Medical Society in this capacity. The expenditure of federal funds for Mental Health Clinics in the State of Illinois, the care of the many wards of the state in mental hospitals, the progress in the revision of the Mental Health Code, all constitute problems considered by the committee.

Since many problems continually arise in the field of mental health, and in the field of hospital care for the mentally ill, the growth of the activities of this committee during coming months might well be watched with interest by members of the profession throughout the state.

*Committee on Military Affairs & Emergency Medical Service.* This committee has concerned itself primarily with the many problems facing this state when "Civilian Defense" is considered. Each member of the committee is a veteran of either World War I or World War II—or in some cases, of both.

A critical survey of the seven target areas and the population centers in Illinois has been conducted by the Deputy Director for Health Services of the Civil Defense Agency of Illinois. A statewide plan for the utilization and allocation of First Aid Stations and improvised hospitals from the strategic and tactical viewpoint has been developed. This plan was studied by the Committee and approved.

At the present time the Committee has a project under consideration whereby an approved booklet dealing with the medical phases of civilian defense, would be placed in the hands of every physician in the state. The Committee stands ready to assist any community desiring to develop a localized plan for civilian defense. As more funds become available, and if and when the needed interest is developed, the Committee will cooperate in any way possible to assist at the local level and to disseminate the information on file and available for any community requesting such counsel and assistance.

*Committee on Necrology.* This committee was organized at the request of the 1952 House of Delegates. The membership was asked to list the deaths of members of the Society during the fiscal year, prepare a short biographic sketch of each, and submit the material as a report to the House of Delegates at each annual session. The work of this Committee is of great service to the Committee on Medical History, since

the biographic files of members can be added to those kept officially at the John Crerar Library by the State Society. The first report of this Committee was made to the House of Delegates in 1953, and was published in the Handbook. A supplementary report was presented verbally by the Chairman to bring the report up to date, and to keep the House informed of the death of members so that proper honor and respect could be paid to those physicians who died during the past year.

*Committee on Nutrition.* The Committee on Nutrition meets with the Friends of the Land (a non-profit organization devoted to the conservation of natural resources and to the better health of the people through proper nutrition). The Committee considers ways and means whereby the subject of Nutrition can best be brought to the attention of the practicing physicians and also medical students. Papers on the subject have been presented at annual meetings of the State Society. Special scientific meetings of county medical societies have been devoted to the subject. A letter to the chairman, Dr. Paul A. Dailey of Carrollton, will receive careful attention; he will be pleased to assist county societies in planning scientific programs devoted to the subject of nutrition, put the program chairman in touch with speakers in this field, and generally assist in any way possible.

The Committee on Nutrition has furnished speakers for a Symposium on Nutrition as a part of the scientific program for the annual meeting of the Society. They are willing and anxious to supply speakers for the General Assembly at all annual meetings, pending approval and correct scheduling by the Executive Committee of the Committee on Scientific Work.

The interest in the field of nutrition has grown and is being fostered and developed by this Committee; its work adds to the efficiency of physicians throughout the state, and contributes to the fund of scientific knowledge available for members of the State Society.

*Committee on Nursing.* For the past two or three years the work of the Committee on Nursing has been growing in importance, and has been confronting various difficulties and problems in the field of nursing. The Committee on Nursing has had to consider the National Accrediting Service, and its actions taken in approving or disapproving schools of nursing in hospitals throughout Illinois. In this state (in August of 1952, for instance) there were 84 schools of nursing, 29 of which were not accredited at that time. Since that date, these various problems have been worked out and in December of 1952 we found that 15 schools of nursing were fully accredited, 41 were temporarily accredited, and 25 were not accredited. By October of 1953, all but 18 schools of nursing were accredited in Illinois. The work for the committee in cooperating with this group continues.

Also, the committee has been represented by its chairman, Dr. M. M. Hoeltgen, at the 14 state conference on the Improvement of Patient Care. This group is developing a Constitution and By-Laws, and the organizations represented shall be the state medical societies, the state hospital associations and the state nurses associations.

The problem presented by the nurses association request that the state society assist them to "legalize venipuncture by nurses" has received careful consideration by the committee. The fact that the enrollment of nurses is down 10% in Illinois schools of nursing was reported by the Illinois Hospital Association. Various remedies are being considered by the committee in cooperation with the Council of the State Society, the members of the Auxiliary to the Illinois State Medical Society, and various other organizations willing to assist in this important problem.

The importance of this committee and its work is obvious. It is another service maintained by the State Society for the members and financed by the payment of society dues.

# CORRESPONDENCE



## ANNUAL CLINICAL CONFERENCE

The Chicago Medical Society's Annual Clinical Conference will be on March 2, 3, 4 and 5, 1954 at the Palmer House, Chicago.

The program follows:

### TUESDAY, MARCH 2

- 8:30 a.m. "Fractures of the Neck of the Femur"  
Dr. Fremont A. Chandler, Professor of Orthopedic Surgery, University of Illinois College of Medicine, Chicago, Illinois
- 9:00 a.m. "Vitamins as Therapeutic Agents"  
Dr. Tom D. Spies, Professor of Nutrition and Metabolism, Northwestern University Medical School; Scientific Director, Nutrition Clinic, Hillman Hospital, Birmingham, Alabama
- 9:30 a.m. "Diagnosis and Management of Breast Tumors"  
Dr. Ferdinand C. Helwig, Clinical Professor of Pathology and Oncology, University of Kansas School of Medicine; Pathologist, St. Luke's Hospital, Kansas City, Missouri
- 10:00-11:00 a.m. Intermission for Review of Exhibits
- 11:00-12:00 a.m. Color Television
- 12:00-1:30 p.m. Luncheon—Round Table Discussion
- 1:30-2:30 p.m. Color Television
- 2:30 p.m. "The Indications for Surgery in the Treatment of Peptic Ulcer"  
Dr. Howard K. Gray, Head of a Section in General Surgery, The Mayo Clinic; Professor of Surgery, The Mayo Foundation, Graduate School, University of Minnesota, Minneapolis, Minnesota
- 3:00-4:00 p.m. Intermission for Review of Exhibits
- 4:00 p.m. "Diseases of the Parotid Glands"  
Dr. James H. Maxwell, Professor of Otolaryngology, University of Michigan Medical School, Ann Arbor, Michigan

4:30-5:30 p.m. Clinicopathologic Conference

### WEDNESDAY, MARCH 3

- 8:30 a.m. "Intracranial Injury"  
Dr. Eric Oldberg, Professor and Head, Department of Neurology and Neurosurgery, University of Illinois College of Medicine, Chicago, Illinois
- 9:00 a.m. "The Role of Stress in Peptic Ulcer"  
Dr. Stewart Wolf, Professor and Head, Department of Medicine, The University of Oklahoma, School of Medicine and University Hospitals, Oklahoma City, Oklahoma
- 9:30 a.m. "Dermatological Disorders Commonly Encountered in General Practice"  
Dr. Marion B. Sulzberger, Professor and Chairman, Department of Dermatology and Syphilology, New York University Postgraduate Medical School and Director of Dermatology, Skin and Cancer Unit, University Hospital, New York, New York
- 10:00-11:00 a.m. Intermission for Review of Exhibits
- 11:00-12:00 a.m. Color Television
- 12:00-1:30 p.m. Luncheon—Round Table Discussion
- 1:30-2:30 p.m. Color Television
- 2:30 p.m. "The Importance of Conservatism in Gynecology"  
Dr. Robert A. Ross, Professor, Department of Obstetrics and Gynecology, University of North Carolina School of Medicine, Chapel Hill, North Carolina
- 3:00-4:00 p.m. Intermission for Review of Exhibits
- 4:00 p.m. "The Early Care of the Severely Injured"  
Dr. Henry K. Beecher, Dorr Professor of Research in Anesthesia, Harvard Medical School; Anesthetist-in-Chief, Massachusetts General Hospital, Boston, Massachusetts
- 4:30 p.m. "The Management of Asymptomatic Solitary

#### Circumscribed Pulmonary Opacities"

Dr. Paul W. Schafer, Professor, Department of Surgery, University of Kansas Medical Center, Kansas City, Missouri

#### 5:00 p.m. "Allergic Reactions to Drugs"

Dr. Harry L. Alexander, Emeritus Professor of Clinical Medicine, Washington University School of Medicine, St. Louis, Missouri

### THURSDAY, MARCH 4

#### 8:30 a.m. "Management of Intestinal Obstruction"

Dr. Robert Elman, Professor of Clinical Surgery, Department of Surgery, Washington University School of Medicine, St. Louis, Missouri

#### 9:00 a.m. "Retinal Complications of Diabetes Mellitus"

Dr. Bernard Becker, Head, Department of Ophthalmology, Washington University School of Medicine, St. Louis, Missouri

#### 9:30 a.m. "The Significance of Hematuria"

Dr. Charles C. Higgins, Head, Dept. of Urology, Cleveland Clinic, Cleveland, Ohio

10:00-11:00 a.m. Intermission for Review of Exhibits

11:00-12:00 a.m. Color Television

12:00-1:30 p.m. Luncheon—Round Table Discussion

1:30-2:30 p.m. Color Television

#### 2:30 p.m. "Use and Misuse of Psychiatry in General Practice"

Dr. Francis J. Gerty, Professor and Head, Department of Psychiatry, University of Illinois College of Medicine, Chicago, Illinois

3:00-4:00 p.m. Intermission for Review of Exhibits

4:00-5:00 p.m. Panel Discussion

"Blood Diseases"

### FRIDAY, MARCH 5

#### 8:30 a.m. "Types of Hypertension"

Dr. Francis D. Murphy, Professor and Head, Department of Medicine, Marquette University Medical School, Milwaukee, Wisconsin

#### 9:00 a.m. "The Medical Treatment of Hypertension"

Dr. Louis Leiter, Clinical Professor of Medicine, Columbia University College of Physicians and Surgeons, Chief, Medical Division, Montefiore Hospital, New York, New York

#### 9:30 a.m. "The Surgical Treatment of Hypertension"

Dr. Reginald H. Smithwick, Professor, Department of Surgery, Boston University School of Medicine, Boston, Massachusetts

10:00-11:00 a.m. Intermission for Review of Exhibits

11:00 a.m. Subject to be announced

Dr. Harvey White, Instructor in Radiology, Northwestern University Medical School; Head, Department of Radiology, Children's Memorial Hospital, Chicago, Illinois

#### 11:30 a.m. "The Present Status of Prophylaxis in Poliomyelitis"

Dr. Henry W. Kumm, Director, The National Foundation for Infantile Paralysis, Inc., New York, New York

12:00-1:30 p.m. Luncheon—Round Table Discussion

#### 1:30 p.m. "Treatment of Hemorrhage in Obstetrics and Gynecology"

Dr. Alan Guttmacher, Director, Department of Obstetrics and Gynecology, The Mount Sinai Hospital; Clinical Professor of Obstetrics and Gynecology, Columbia University, New York, New York

#### 2:00 p.m. "Infection in the Newborn"

Dr. Stewart H. Clifford, Assistant Clinical Professor of Pediatrics, Harvard Medical School, Visiting Pediatrician, Boston Lying-In Hospital; Chief of the Premature Service, Children's Medical Center, Boston, Massachusetts

#### 2:30 p.m. "Medical Infections of the Kidney"

Dr. J. Murray Kinsman, Professor and Chairman, Department of Medicine; Dean, University of Louisville School of Medicine, Louisville, Kentucky

3:00-3:30 p.m. Intermission for Review of Exhibits

3:30-4:30 p.m. Panel Discussion

"Obstetrics and Gynecology"

### DAILY TEACHING DEMONSTRATIONS

Liver Function Tests

Fluid and Electrolyte Balance in Surgery

Laboratory Aids in General Practice

Functional Aspects of Gastrointestinal Disorders

Speech Without Larynx

Obstetrics Clinic

Mental Retardation in Children

Radiology Clinic

Hand Injuries

Neurology Clinic

Heart Surgery

Diabetes Clinic

## MISSISSIPPI VALLEY MEDICAL SOCIETY 1954 OFFICERS AND DIRECTORS ELECTED

The 1954 Mississippi Valley Medical Society officers recently elected were as follows: President-Elect, Arthur S. Bristow, M.D., Princeton, Mo., Past-President, Missouri State Medical Ass'n; 1st Vice Pres., Murray E. Rolens, M.D., Springfield, Ill; 2nd Vice Pres., Preston G. Hall, M.D., St. Louis; 3rd Vice Pres., George C. McGinnis, M.D., Ft. Madison, Ia; Sec.-Treas., Harold Swanberg, M.D., Quincy, Ill; Asst. Sec.-Treas., Jacob E. Reisch, M.D., Springfield, Ill; Accounting officer, Thomas F. Harmon, M.D., Springfield, Ill.

The new directors elected were: G. E. Kirby, M.D., Spring Valley, Ill., D. M. Gover, M.D., Springfield, Ill., A. F. Goodyear, M.D., Decatur, Ill., A. M. Vaughn, M.D., Chicago, S. E. Lawton, M.D., Chicago, L. L. Hardt, M.D., Chicago, W. I. Lewis, M.D., Herrin, Ill., A. W. Neilson,

St. Louis, George T. Gafney, M.D., St. Louis, A. S. Bristow, M.D., Princeton, Mo., L. A. Block, M.D., Davenport, Ia., and Paul Leehey, M.D., Independence, Ia.

Dr. Norris J. Heckel of Chicago, Prof. of Urology, University of Illinois, is the 1954 President. The 19th annual meeting will be held at the Hotel Sherman, Chicago, Sept. 22-24. The 11th annual meeting of the American Medical Writers' Association will meet at the same hotel, Sept. 24.

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## AMERICAN GERIATRICS SOCIETY

The 11th Annual Meeting of the American Geriatrics Society will be held at the Hotel Fairmont in San Francisco just preceding the meeting of the American Medical Association. The scientific sessions of the meeting will begin Thursday afternoon, June 17 and continue through Saturday morning, June 19.

Hotel reservations should be made through the San Francisco Convention and Visitors Bureau, 200 Civic Auditorium, San Francisco 2, California. Members should reserve accommodations immediately, stating time of arrival and departure date, because the hotels expect to be filled to capacity.

The Annual Business Meeting will be held in the Fairmont Hotel Thursday morning, June 17, at 9 o'clock. The room for this meeting will be announced later. All Scientific Sessions will be held in the Nob Hill Room of the Fairmont, and the annual dinner is scheduled for the Gold Room on Friday evening, June 18.

The meeting will be open to all members of the American Geriatrics Society and to physicians and other scientists who are interested in the field of geriatrics. The program will cover many aspects of geriatric medicine, and there will be several panel discussions on such subjects as recent developments in cardiology and methods of determining operability in older patients. Outstanding clinicians and investigators will participate.

Dr. Laurance W. Kinsell, Highland Alameda County Hospital, 2701 Fourteenth Avenue, Oakland 6, California, is in charge of local arrangements for the meeting.

W. O. Thompson, M.D.  
President  
700 North Michigan Avenue  
Chicago 11, Illinois

## MICHIGAN CLINICAL INSTITUTE

Color television direct from the operating room will be one of the unusual attractions added to the program of the Eighth Annual Michigan Clinical Institute at the Sheraton-Cadillac Hotel, Detroit, March 10, 11, and 12, according to Wilfrid Haughey, M.D., of Battle Creek, general chairman.

With cooperation from staffs of major Detroit hospitals, daily telecasts of surgical and other procedures will be beamed to the convention, Dr. Haughey said. In other meetings, newest scientific information, valuable to the practicing doctor of medicine, conveniently grouped in six "blocks" according to subject, will be presented by 27 outstanding medical lecturers.

During the three-day session, meetings will be arranged in blocks of three to five lectures dealing with a medical specialty or subject. "Blocks" presentations have been scheduled for each of the following: surgery, trauma, obstetrics-gynecology-pediatrics, internal medicine, heart and general medicine. There will also be a special diabetes lecture, the annual R. S. Sykes Lecture on a cancer topic, and the annual Michigan Foundation for Medical and Health Education, Inc., Lecture, dealing this year with poliomyelitis vaccination.

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## CHICAGO PEDIATRIC SOCIETY MEMORIAL SERVICE

The Chicago Medical Society in Joint session with the Chicago Pediatric Society will hold a memorial meeting for Dr. Louis S. Robins. Dr. Robins was an outstanding pediatrician in Chicago who succumbed to myasthenia gravis. His many friends will appreciate knowing there is to be a memorial meeting in his name. The meeting will be held on Tuesday, Feb. 16, 1954, in the Nurse's Home Auditorium of Children's Memorial Hospital, 707 W. Fullerton Avenue at 8:00 P.M. The program will be as follows: "His Early Years" Dr. Sidney O. Levinson\* "His Illness" Dr. William Saphir & Dr. Otto Saphir\* "Myasthenia Gravis" Guest Speaker: Lee McKendree Eaton\* Professor, Neuro-Psychiatry Mayo Foundation.

\*By invitation

# COUNCIL MEETING MINUTES



The December meeting of the Council of the Illinois State Medical Society was held at the Hotel Sherman, Chicago, on Sunday, December 13, 1953. The following were present: Lewis, Vaughn, Nicholson, Lundholm, O'Neill, Stone, Hellmuth, Piszczek, Oldfield, Reichert, Blair, Camp, Reisch, Goodyear, Newcomb, English, Montgomery, Fullerton, Hamilton, Sweeney, Hopkins, Cross, Limarzi, Mr. J. W. Neal, Mr. James C. Leary, William DeHollender, Bornemeier, Fowler, C. Elliott Bell, Leonard Schuman, Hoeltgen, VanDellen, Robert Hayes and Frances Zimmer. Minutes of the previous meeting were approved as mailed to members.

President Lewis reported on his activities since the last meeting; he attended the Annual Meeting of the Indiana State Medical Association at French Lick, where the first meeting of the House of Delegates was held on Sunday, the reference committees on Monday, which arrangement did not interfere with their scientific sessions. He attended the Post Graduate meetings at Sterling, Jacksonville, Benton, and Kankakee, all of which were well attended and with excellent presentations. He officiated at the annual meeting of the Committee on Scientific Work, to get the programs for the 1954 annual meeting under way. He attended the Clinical Session of the A.M.A. in St. Louis, December 1-4, commenting on some of the problems presented there.

Vaughn gave his report as President-Elect telling of meetings he had attended, including the post graduate conference at Cairo, the A. M. A. Session and other meetings which he attended as an official representative of this Society. Camp gave a supplementary report as Secretary and Treasurer, some matters not included in the report mailed to members prior to the meeting. The financial report had been mimeographed, and was passed out to all members during the morning.

Stone reported as Chairman of the Council, telling of the complimentary statements made concerning the

discussions of Dr. Reichert at the Conference of Physicians and Schools held at Highland Park by the A. M. A. Stone told of a number of meetings he had recently attended. Also referred to the request received from the A. M. A. House of Delegates requesting the selection of a special committee to review the Cline Report presented to the A. M. A. House of Delegates, relative to the Osteopathic situation. It was desired that this report and its recommendations be referred and discussed within the individual states so the delegates from the several states to the A. M. A. House of Delegates in San Francisco next June would have the recommendations on the subject of their own State Society. The committee consists of Hesseltine, Chairman, Sweeney and Reisch. Stone told of the arrangement for the three meetings of the House of Delegates during the 1954 annual meeting; 1st meeting, Tuesday May 18, at 9:00 A. M., Second meeting, Thursday, May 20, at 3:00 P. M., and the third meeting, Friday morning, May 21, at 8:30.

Hopkins reported as Chairman of the Committee on Medical Service and Public Relations, referred to a meeting of his committee the previous day. Told of a report being prepared by the Committee on Industrial Health, relative to workmen's compensation laws, and many other problems concerning industrial health. The committee has held several meetings and hopes to have its material ready in the near future, which if approved by the Council, will be made available in the form of a brochure. The Committee will submit this material also to the Chicago Medical Society and no action is necessary at this time. The Committee is considering the development of an exhibit to be shown at the San Francisco A. M. A. meeting next June. Mr. Neal discussed the Bricker Amendment, which he believes will be an important matter before the federal congress at its meeting the first of the coming year. The Commit-

tee on Medical Service believes this amendment is most desirable and should be approved by this Society. Motion: Sweeney-O'Neill, that the Council favor such action. Motion carried. Mr. Leary told of his work as Director of Public Relations, referred to his P. R. Pamphlet recently printed, and its increasing popularity. Neal then read a letter he had sent to Hopkins, as Chairman of the Committee on Medical Service and Public Relations, in which he submitted his resignation as Secretary for the Committee. This was a very reluctant decision, but he believes it best that he now limit his activities after 12 years with the State Society. He proposed to complete several projects now under way. There were a number of those present commenting on Neal's resignation and complimenting him for the fine work he has done for this Society over the 12 year period. English recommended that the Committee should find and recommend a successor to Neal, then bring their recommendation to the Council for proper action. Motion: English-Goodyear, that this be done. Motion carried. Blair reported on recent activities of the Educational Committee, telling of the development of a Television program under the auspices of the Rock Island County Medical Society. He and Miss Fox recently met with the Public Relations Committee of that Society and left scripts with that committee for study. The Winnebago County Society also is establishing a county society TV schedule and their Executive Secretary has visited the Chicago office going over scripts and other material. Blair told of the requests received for Health Talk, which is now printed in many of the Illinois papers. Limarzi, as Chairman of the Scientific Service Committee, told of the current review of list of speakers and subjects which he hopes to have published in the near future. Letters were sent to the Deans of the five Illinois Medical Schools asking their aid in developing the new list revision. Limarzi told of the long list of county societies now using the services made available for them by his committee.

Montgomery told of the three P. G. conferences held in his district. All were excellent programs, well attended, and he wanted to thank Doctor Hellmuth on the present series being conducted throughout Illinois. The I. P. A. C. Medical Advisory committee met the previous evening, and they had a long agenda, as usual. Montgomery reported on some actions taken, and referred to the plan of having several County Society Advisory Committee members present at each of these meetings to better inform them on the responsibilities of this State Society Committee.

Hellmuth, as Chairman of the P. G. Committee, gave a progress report, telling of the conferences held during the fall series, the type of programs, the good attendance and interest. Eight major and three smaller conferences were held in the series so far. The winter months will not see any conferences scheduled, but a number have been tentatively arranged for the spring series, perhaps eight or 10 in all before the annual meeting next May. Hellmuth discussed the proposed survey which he believes should be conducted if possible. This report was discussed by a number of members.

Hamilton, as Chairman of the Finance Committee, informed Doctor Hellmuth that the sum of \$7,500 had been appropriated for the Post Graduate series for the fiscal year. If there should be a balance from this appropriation, the committee would not object to its being used to supplement other funds for making the survey. Motion: Sweeney-Vaughn, that the recommendation of the Finance Committee be approved. Motion carried.

Hoeltgen told of the nursing situation, as seen by his Committee on Nursing. He stated that nursing enrollment is reported as being down 10% in Illinois training schools. Various plans being used in other states were reported by Hoeltgen. The report was to be considered a progress report.

Motion: Hamilton-Fullerton, that the Society pay the annual dues for membership in the Illinois Chamber of Commerce. Motion carried. Motion: Sweeney-Piszcsek, that the Council approve the Finance Committee's recommendation that "Today's Health" be sent to members of the state and federal legislature from Illinois, with the compliments of this Society. Motion carried.

Motion: Hamilton-Fullerton, that the \$25.00 membership dues in the Illinois Public Health Association be paid. Motion carried. Motion: Hamilton-Sweeney, that the \$10.00 dues for the Illinois Civic Exchange be paid. Motion carried.

Reports of the individual councilors were received. Fullerton told of the Cairo Post Graduate meeting, at which he presided; good attendance and an excellent program well received. Goodyear stated that his guest at the meeting was C. Elliott Bell of Decatur, and he would like to have permission to have Doctor Bell present the Macon County Health Insurance Project to the Council. Permission given by the Chairman. Bell stated that although the insurance problem in the health field is one which must be solved at the county, state and A. M. A. levels, it has been generally agreed that the proper consideration of health insurance must be solved at the county level. He passed out copies of a report from his Society, which represents county and community cooperation and work. The material had been approved by the Chamber of Commerce, by industry, social service, the hospitals, nurses association and by other groups. The survey made in Macon County of medical costs is in line with the situation found in other Illinois counties. He believes this material can be of assistance to all county societies in the field of health insurance. Blue Cross-Blue Shield believes this is an opportunity to work with them, and Blue Shield will offer their contract. They are going to be able to give a contract which will be uniform to an annual income of \$4,000 or less, which is the average income in Decatur. The insurance companies will have to work with people in higher income groups. Bell stated that they propose to have a conference in Decatur where their material will be submitted and he would like to see many representatives from other counties present. He asked the Council to approve the conference and to encourage representatives of other

county societies to attend their meeting. Motion: Good-year-English, that the Council approve this proposed conference. Motion carried.

Newcomb reported on the Post Graduate Conference held at Jacksonville, where the program was excellent, and with a good attendance. O'Neill attended the Post Graduate Conference held in Sterling, where he presided, and the one held in Kankakee. He believes the series recently held were all fine, and with good public relations in all counties the attendance can be improved.

Reisch and Lundholm discussed problems within their respective districts. Lundholm also reported on the activities of the Winnebago County Auxiliary to raise funds for nurse recruitment. A net of some \$14,000.00 was raised, which shows what the Auxiliary can do to help the medical profession. Goodyear stated that the Macon County Society Auxiliary is starting a scholarship fund for nurses, and their interest and progress are most satisfactory. Piszczek told of a recent meeting he attended of the Illinois Interprofessional Council, with representatives of each participating group

present for a dinner meeting. He hoped more physicians would attend these interesting conferences regularly.

Hayes reported as Chairman of the Committee on Medical Benevolence, giving the number of recipients, the expenditures, etc. No names are ever given of the recipients, these known only by the members of the committee and the local society sponsor.

A list of candidates for Emeritus Membership appeared on the agenda. Motion: Hamilton-Sweeney, that they be elected to Emeritus Membership. Motion carried. There was one candidate recommended by his component society for Retired Membership. Motion: Piszczek-Newcomb, that he be so elected. Motion carried.

Motion: Lewis-Piszczek, that the bills as audited by the Finance Committee be approved. Motion carried. Motion: English-Ramilton, that the meeting previously scheduled for January 10, be left to the discretion of the Chairman of the Council. Motion carried.

Council adjourned to 2:30 P. M.

Harold M. Camp, M. D.  
Secretary-Treasurer

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## I.Q. IN C.P.

About one-third of the entire group of cerebral palsied children have been found to be uneducable by reason of mental deficiency. This figure is much lower than was originally realized. Many cerebral palsied children have been incorrectly classified as mentally retarded because of their facial grimaces, drooling, lack of coordinated speech, and other conditions seen in the imbecile. Two-thirds of these children, however, have I.Q.'s of 70 or higher and more than half are of normal or superior intelligence, have the personality characteristics of nonhandicapped children, and are unquestionably teachable. *Paul A. Draper, M.D., Teamwork in Cerebral Palsy. Rocky Mountain M.J., Dec. 1953.*

## EVALUATING AN ADOPTED CHILD

Everyone agrees that an adopted baby should be sound in mind and body, but there is a wide difference of opinion as to when this evaluation can be made. One of our most prominent authorities believes that such an evaluation cannot be made until the child is one year old. Other equally capable authorities believe that if the pregnancy history and the type of delivery is known, a capable pediatrician, observing a baby for as short an interval as three weeks, can make a fair estimate of its intellectual and physical capabilities. These are the two extreme views. The truth probably lies somewhere in between. *Georgeanna Seegar Jones, M.D., Medical Aspects (of Adoption). Maryland M.J., Nov. 1953.*

## NEWS OF THE STATE



### COOK

**Rehabilitation Institute.**—Dr. Ben L. Boynton, recently appointed professor of physical medicine and rehabilitation at Northwestern University Medical School, has been named director for the new Rehabilitation Institute of Chicago. The institute, a nonprofit organization, is patterned after the New York University-Bellevue Medical Center Institute of Physical Medicine and Rehabilitation but, according to the Journal of the American Medical Association, will be a civic undertaking, not operated in connection with any particular hospital or medical school. The Journal reported that the institute services will be available to all who qualify for rehabilitation, at standard rates established by the institute according to the individual needs of each patient. It will have on its staff consultants in all the medical specialties and a job placement officer to help rehabilitated patients secure work within the limits of their capabilities on a competitive basis among nonhandicapped persons.

**The Annual Bacon Lecture.**—Dr. S. R. M. Reynolds, an authority on the physiology of reproduction and pregnancy, delivered the annual Charles Sumner Bacon lecture at the University of Illinois College of Medicine, January 14. His subject was "Circulatory Adaptations at Birth and Their Management in the Newborn." Dr. Reynolds is a member of the staff of the department of embryology at Carnegie Institution of Washington, and a lecturer in obstetrics at Johns Hopkins University School of Medicine, Baltimore.

**Institute of Medicine Chooses New Officers.**—Dr. Willis J. Potts was chosen president of the

Institute of Medicine of Chicago at a recent meeting. Other officers are Dr. Don C. Sutton, vice president; Dr. George H. Coleman, secretary, and Dr. E. Lee Strohl, treasurer. Dr. Henry T. Ricketts continues as Chairman of the Board of Governors. Other board members for the year 1954 are Drs. Richard B. Capps, Warren H. Cole, Arthur R. Colwell, Charles W. Freeman, Warren W. Furey, Edwin F. Hirsch, Ernest G. McEwen, Vincent J. O'Connor, Charles B. Puestow, John Lester Reichert, Herbert E. Schmitz, Walter H. Theobald. Citizen Fellowships conferred at the meeting went to Mr. Maurice Goldblatt, chairman of the board of the University of Chicago Cancer Research Foundation; Mr. Robert T. Sherman, president of the board of the Chicago Blue Cross Plan for Hospital Care, and Mr. John P. Wilson, who has served as president of the board of the Children's Memorial Hospital for twenty-five years.

**Lectures on Virology.**—The Chicago Medical School opened a lecture series January 12, with Salvador A. Luria, Urbana, speaking on "The Nature of Viruses." Other lectures in the series include the following: John E. Kempf, January 19, speaking on "The Pathogenesis of Virus Diseases"; February 2, Albert Milzer, on "The Development of Virus Vaccines"; February 9, William I. Fishbein, on "Epidemiology of Certain Virus Diseases"; February 16, Fred. M. Davenport, Ann Arbor, Michigan, on "Newer Knowledge of the Epidemiology of Influenza"; February 23, James G. Shaffer, on "Rabies", and March 2, Harry B. Harding, on "Survey of Recent Advances in the Laboratory Diagnosis of Virus and Rickettsial Diseases".

**Grants For Research.**—Charles Pfizer and Company, Brooklyn, has renewed a grant in the amount of \$6,000 for work of an investigative nature in infectious diseases, preventing medicine, and related fields. The research is being carried out under the direction of Dr. Harry F. Dowling. A \$2,000 grant was made available by Abbott Laboratories, North Chicago, for the study of the effects of idiôt concentration nutrients and drugs in preventing or curing demyelization in rats and its relationship to multiple sclerosis. This work is under the direction of Dr. Robert M. Kark. Abbott has also renewed a grant in the amount of \$1,600 in support of a study of connective tissue which is being conducted by Dr. Max Samter.

**Personal.**—Dr. Jack Mason and Dr. Louis H. Turek, clinical instructor and assistant in medicine, respectively at the Chicago Medical School, have been appointed associates to Dr. Edwin R. Levine on the tuberculosis ward of Cook County Hospital. Dr. Levine is assistant clinical professor at the Chicago Medical School.—Dr. Noel D. Shaw, Evanston, was recently elected president of the medical staff at St. Francis Hospital. New vice president is Dr. George H. Irwin and secretary-treasurer, Dr. Maurice W. Sbertoli.

**Lectures in Psychiatry.**—"Treatment in Psychiatry" is the theme of a series of lectures comprising the Fourth Annual North Shore Health Resort Lecture Series. Dr. Harold G. Wolff, professor of medicine, Cornell University Medical College, opened the series October 7 on "The Problem of Psychiatric Referral." Other lecturers include Dr. Marc H. Hollender, Chicago, November 4, on "What is Psychoanalysis?"; Dr. Rudolf Dreikurs, Chicago, December 2, on "What is Psychotherapy?"; Dr. Howard P. Rome, Rochester, January 6, on "The Role of a Psychiatrist in a Hospital"; Dr. Lothar B. Kalinowsky, New York, February 3, on "The Use of Shock Therapy and Psychosurgery"; Dr. Jules Henry, St. Louis, March 3, on "The Role of the Family in Emotional Disorders"; Dr. Irene M. Josselyn, Chicago, April 7, on "The Treatment of Children"; Dr. Kenneth Appel, President, American Psychiatric Association, May 12, on "The General Practitioner and the Discharged Psychiatric Patient"; and Dr. Daniel Blain, medical director, American Psychiatric Association, June 2, on "How the General Practitioner Can Contribute Toward Healthy Emotional Development."

**Society News.**—Dr. John B. Schwedel, assistant clinical professor of medicine, Columbia University College of Physicians and Surgeons, New York, addressed "Roentgenology of the Normal and the Abnormal Heart" at the meeting of the Illinois Chapter of the American College of Chest Physicians in Chicago, December 11. Discussion was opened by Drs. Benjamin M. Gasul, associate clinical professor of medicine, University of Illinois

College of Medicine and Harvey White, head of the department of radiology, Children's Memorial Hospital. Dr. Joseph K. Narat addressed the Chicago Veterinary Society at a meeting in the Palmer House, November 10. His subject was "Application of Surgical Procedures in Man to Canine Surgery."—Miss Vera M. Binks, Director of the Illinois State Department of Registration and Education, Springfield, addressed the Chicago Council on Community Nursing, January 18, on "Community Nursing From the Standpoint of the Department of Registration and Education."

**Grants-in-Aid.**—Over \$30,000 in new grants for research have been received recently by The Chicago Medical School, as announced by President John J. Sheinin. They are: \$2,100 from the Lasdon Foundation (Nepera Park) to Dr. David M. Cohen, Department of Dermatology and Syphilology, for studies of drugs used in treatment of superficial fungus infections of the skin. \$3,815 from the Office of Naval Research to Dr. Piero P. Foa, Department of Physiology, Pharmacology and Therapeutics, for research in experimental diabetes. \$8,600 from the Tuberculosis Institute of Chicago and Cook County to Dr. Aldo A. Luisada and Edwin R. Levine, Division of Cardiology, for research in cardio-pulmonary physiology of chronic cor pulmonale. \$1,500 from the Oscar J. Cogan Heart Foundation to the Division of Cardiology for purchase of new apparatus employing radioactive materials in study of patients with heart disease. Work will be conducted under the supervision of Dr. Aldo A. Luisada, assisted by Dr. A. Robert Goldfarb, Department of Biochemistry. \$7,500 from Baxter Laboratories to Dr. James G. Shaffer and Dr. William H. Schlaes, Department of Microbiology and Public Health, for investigations of diagnostic tests in amebiasis. \$2,500 from Eli Lilly and Company to Dr. James G. Shaffer for investigation of new drugs in the treatment of amebiasis. \$4,860 from the Damon Runyon Memorial Fund to Dr. Philippe Shubik, Division of Oncology, Department of Surgery, for a study of metastatic dissemination of tumors induced by cortisone.

**Hospitals Receive Gifts.**—A total of \$2,500,000 in gifts was announced December 10 at a dinner in the Morrison Hotel sponsored by the Jewish Federation of Chicago. The federation goal is \$3,750,000 for the expansion of Michael Reese and Mount Sinai hospitals. According to the Chicago Tribune, a family gift of \$500,000, the largest single contribution, was made by the widow and nine children of Max S. Kaplan, founder of the scrap iron business bearing his name. The proposed expansion program of the two hospitals will include a new 120 bed pavilion at Michael Reese, complete the new power plant, and rebuild three floors at Mount Sinai to provide an additional 60 beds.

**Dr. Theobald Reelected Head of Medical Center**

**Commission.**—Dr. Walter H. Theobald was re-elected president of the West Side Medical Center Medical Commission and Dr. Karl A. Meyer, medical superintendent of county institutions, was re-elected vice president. C. Hilding Johnson and Carl Stockholm were named secretary and treasurer respectively. The Commission was created a number of years ago to develop the West Side Medical Center area, which work has been going on for quite some time.

#### DE WITT

**Joint Tuberculosis Effort.**—The DeWitt County Medical Society working with the DeWitt County Tuberculosis Association, administered tuberculin skin tests to about one hundred and fifty high school students in Clinton recently. Members of the county medical society are active in a number of civic organizations pertaining to health as well as in non-medical civic groups. These include the Unit School Board, the County Cancer Society, the County Sanatorium Board, the County Poliomyelitis Association, the Chamber of Commerce and such groups as the Rotary and Kiwanis Clubs. The county medical society was addressed recently by Dr. Jacob Reisch, Councilor of the Fifth District, and by Dr. William Requarth, Decatur. The latter's subject was "Infections of the Hand".

#### DU PAGE

**Society Election.**—At the December 16 meeting of the DuPage County Medical Society, Dr. John R. O'Donnell, Glen Ellyn, was named president. Dr. Dan D. Jamison, Wheaton, was elected vice-president and program chairman, and Dr. Samuel K. Lewis, Elmhurst, was named secretary and treasurer pro tem. The permanent secretary, Dr. A. R. Rikli, Naperville, is ill in Copley Hospital, Aurora. Dr. Elvin L. Sederlin, health officer of DuPage County and members of his staff provided the program covering nutrition, school health and county ordinances as they may involve the general physician. The society passed a resolution stating that the county board of supervisors be informed that the DuPage County Medical Society would favor a county wide pure milk ordinance.

#### EDGAR

**Society Observes Fiftieth Anniversary.**—On November 5, 1953, a banquet was held at the Elk's Club in Paris to observe the fiftieth anniversary of the Edgar County Medical Society. The woman's auxiliary to the society acted as hostess. Guest of honor was Dr. Francis M. Link, Paris, the only living charter member. Dr. Paul E. Fleener, president of the society, was toastmaster.

#### LEE

**New Officers.**—Dr. Charles Lesage, Dixon, was elected president of the Lee County Medical Society at its recent annual meeting. Dr. T. J. Caldorola, Franklin Grove, was named secretary-treasurer and Dr. H. M. Edwards, Jr., Dixon, program chairman.

#### MADISON

**Society News.**—Dr. C. Elliott Bell, Decatur, president of the Macon County Medical Society, addressed the Madison County Medical Society at St. John's Methodist Church, Edwardsville, January 7 on "Public Relations." The society was addressed in December by Dr. James F. Dowd, St. Louis, on "Plastic Surgery of the Hand."

#### OGLE

**Rochelle Resident Honored By Chamber of Commerce.**—Dr. Lloyd T. Koritz, Rochelle, now serving his internship at Cook County Hospital in Chicago, was recently announced as one of the nation's ten outstanding young men of 1953, newspapers reported. The selection was made by the United States Junior Chamber of Commerce. Dr. Koritz, who plans to return to his native town of Rochelle to engage in private practice, was honored for risking his life as a human guinea pig in experiments in artificial respiration while he was a medical student at the University of Illinois College of Medicine.

#### ROCK ISLAND

**Hospital News.**—Rock Island County has just completed a 132 bed addition to its Rock Island County Convalescent Home, Coal Valley. The formal opening was held with appropriate ceremonies November 29.

#### SANGAMON

**Society Election.**—Dr. George B. Stericker is the new president of the Sangamon County Medical Society. Other officers are Drs. Thomas Harmon, vice-president, and William DeHollander, secretary-treasurer. Delegates to the Illinois State Medical Society are Drs. Darrell H. Trumpe and Kenneth Schnepf. Alternate delegates are Drs. J. Marvin Salzman and Jacob E. Reisch.

**First Memorial Meeting.**—On January 7 the Sangamon County Medical Society inaugurated an annual memorial service for the physicians who died during the previous year. The Very Reverend David K. Montgomery, Dean of St. Paul's Cathedral, Springfield, conducted the first memorial service for Drs. Richard F. Herndon, Richard B. Hull and Franklin Maurer, members of the Sangamon County Medical Society, who died in 1953. Rev. Montgomery was introduced by Dr. Murray E. Rolens, whose last official duty was to pay tribute to those members who died during his term of office. The establishment of a memorial service at each January meeting was instituted by the addition of an amendment to the society's by-laws at the December, 1953, meeting, according to the Bulletin of the Sangamon County Medical Society. After the memorial service, Dr. Robert Elman, clinical professor of surgery, Washington University School of Medicine, spoke on "Chronic Recurrent Pancreatitis".

## VERMILION

**New Society Officers.**—Dr. R. E. Bucher, Danville, was elected president of the Vermilion County Medical Society at its recent meeting in Danville. Other officers elected are Dr. E. M. Dewhirst, vice president, and Dr. L. W. Tanner, secretary-treasurer. The society was addressed, January 5, on "Recent Advances in Intestinal Surgery."

## WARREN

**Society News.**—Dr. C. Paul White, Kewanee, former president of the Illinois State Medical Society, addressed the Monmouth Rotary Club, November 16. Title of Dr. White's address was "Your Health As This Doctor Sees It."

## WINNEBAGO

**Society News.**—Wayne E. Swanson, chief of the Rockford fire department, addressed the Winnebago County Medical Society, January 29. His subject was titled "It's Been Burning Me for a Long Time." Dr. Jerome Head, Chicago, addressed the December 15 meeting of the Winnebago County Chapter of the American Cancer Society on lung cancer. Supplementing Dr. Head's talk was the first Rockford showing of the short movie "The Warning Shadow", a film dealing with lung cancer which is of interest to both non-medical and professional people.

## GENERAL

**Pilot Study in Morgan County on New Polio Vaccine.**—In mid-December, a preliminary pilot study to determine the value of a new irradiated polio vaccine was to have been launched in Morgan County, according to the Illinois Department of Public Health. The vaccine to be used was prepared by the Michael Reese Research Foundation and the Illinois Department of Public Health Laboratory. Parents interested in obtaining injections for eligible children were asked to contact the Morgan County Health Department to arrange dates. Parents had to give their written consent before the injections were given. The project was conducted jointly by the State Health Department, the Morgan County Health Department and the Morgan County Medical Society. The study included an analysis of a blood sample from each child receiving the vaccine to determine how much immunity the child has for each of the three types of polio before the injections were given. Another analysis of a blood sample taken after the injections determined the amount of immunity which the vaccine produced. Because the laboratory work involved in this type of study is highly detailed and expensive, only a limited number of children were used. If the studies prove satisfactory, parents of children included in the study may have the vaccine given to all other children in their immediate family under the age of eighteen. Volunteers who met the following specifications were requested for the preliminary

study: (1) Children who had reached their fourth birthday but had not reached their eighth birthday; (2) Must be in good health and of average weight; (3) Preference was given to children who have resided their entire lives in Morgan County. In no instance was a child accepted who had lived less than the last four years in Morgan County; (4) There must have been no history of a polio case in the immediate family during the lifetime of the child; (5) Preference was given to rural residents if there were more applicants than needed for the preliminary study.

**New Appointments to Health Agencies.**—Governor William G. Stratton on December 31 announced appointments to the Hospital Licensing Board, the Advisory Board to the Bureau of Cancer Control, and the Advisory Hospital Council, all agencies under the Department of Public Health.

The seven-member Hospital Licensing Board was created under an act passed at the last session of the legislature. The act makes all hospitals in Illinois, except federally-owned institutions and hospitals operated or licensed by the state Department of Public Welfare and Public Safety, subject to licensing by the health department. The new board will advise the department and approve licensing requirements.

The board consists of seven members, including two doctors, three hospital administrators and two public members of hospital governing boards. The act provides that of the original appointments two of the terms will be for one year, two for two years and three for three years. Members appointed subsequently will hold office for three years. Those named by Governor Stratton, and their terms, are:

Dr. Theodore R. Van Dellen, 435 North Michigan Ave., Chicago, June 30, 1956; Dr. Harlan English, 139 North Vermilion St., Danville, June 30, 1954; Msgr. John W. Barrett, 31 East Congress, Chicago, June 30, 1955; George K. Hendrix, executive director Memorial hospital, Springfield, June 30, 1954; Dr. George H. Van Dusen, Christian Welfare hospital, East St. Louis, June 30, 1956; I. R. Abbott, president of the board of trustees of the Decatur and Macon county hospital, June 30, 1955; and Elmer E. Abrahamson, 120 South LaSalle St., Chicago, secretary of the board of trustees, Norwegian-American hospital, Chicago, June 30, 1956.

Members appointed to the Advisory Board to the Bureau of Cancer Control are: Dr. Fred Decker, Methodist hospital, Peoria, to fill the unexpired term of the late Dr. Roswell T. Pettit; Dr. Gilbert Edwards, Pinckneyville, reappointed; and Dr. James P. Grier, Evanston, reappointed. This board has four other members whose terms have not expired.

Governor Stratton appointed Robert Levis II, of Alton, to replace May C. Busch, Salem, on the Advisory Hospital Council. He also reappointed Fannie Brooks, Urbana; Dr. I. H. Neece, Decatur; and

Msgr. John W. Barrett, Chicago. There are 11 other members on this council with terms not yet expiring.

**"Your Doctor Speaks" over FM Station WFJL.**—Since the last issue of the Illinois Medical Journal, the following physicians have appeared in transcribed broadcasts in a series **"Your Doctor Speaks"** over FM Station WFJL:

**E. Clinton Texter, Jr.**, associate in medicine, Northwestern University Medical School, January 7, "The Peptic Ulcer Problem."

**Alexander N. Ruggie**, assistant instructor in medicine, University of Illinois College of Medicine, January 14, on "Rheumatism, What It Should Mean to You."

**"Your Doctor Speaks"** is presented under the auspices of the **Educational Committee of the Illinois State Medical Society** in cooperation with FM Station WFJL.

**Lectures Arranged Through the Educational Committee of the Illinois State Medical Society:**

**Donald A. Dukelow**, Clarendon Hills Woman's Club, Clarendon Hills, February 1, on Superstitions of Health.

**Bernice S. Rosen**, Woman's League for Crippled Children, February 3, on What Do You Know About Sex?

**William H. Wehrmacher**, Chicago Uptown Lion's Club, February 11, on Heart Disease.

**Elfriede Horst**, Proviso Township Newcomer's Club in Des Plaines, February 13, on Problems of Parenthood.

**G. W. Wormley**, Rockford, Holy Trinity Mother's Club in Elgin, March 16, on Diseases of the Ear.

**Joseph K. Freilich**, Audubon School Parent Teacher Association, March 16, on Tuberculosis.

**Adrian D. M. Kraus**, Kohn School Parent Teacher Association, March 18, on The Health of the School Child.

**Miss Ann Fox**, Princeton Woman's Club in Princeton, March 22, on There's No Business Like Medical Business.

**John A. Mart**, Northwest Branch Auxiliary to the Chicago Medical Society, March 23, on Living With Your Heart.

**Lectures Arranged Through the Scientific Service Committee of the Illinois State Medical Society:**

**Charles D. Krause**, Chicago, Knox County Medical Society in Galesburg, January 21, on The Rh Factor in Obstetrics.

**Adrien Ver Bruggen**, Chicago, Macon County Medical Society in Decatur, January 26, on Acute Head Injuries.

**Ormand C. Julian**, Chicago, St. Clair County Medical Society in East St. Louis, February 4, on Present Status of Peripheral Arterial Surgery.

**Lawrence Breslow**, Chicago, Knox County Medi-

cal Society in Galesburg, February 18, on Infant Feeding and Colic.

**Jerome T. Paul**, Chicago, Marion County Medical Society in Centralia, February 18, on The Management of the Diabetic Patient.

**George M. Cummins, Jr.**, Knox County Medical Society in Galesburg, March 18, on Some Cardiovascular Aspects of Aging.

**Wayne B. Slaughter**, Lee-Whiteside County Medical Societies, Dixon, March 18, on Early Treatment of Traumatic Injuries in Children.

**Walter J. Reich**, DeKalb County Medical Society in Sycamore, March 23, on Diagnosis and Management of Common Gynecological Problems.

**"All About Baby"** over WBKB.—Since the last issue of the Illinois Medical Journal, the following physicians were scheduled to appear in the telecast **"All About Baby"** which appears daily over Station WBKB:

**Lars E. Lundgoot**, senior pediatrician, St. Elizabeth's Hospital, January 13.

**Karl L. Bergener**, member pediatrics staff, St. Mary's Hospital in Kankakee, January 20.

**John S. Hyde**, Oak Park, clinical instructor in pediatrics, University of Illinois College of Medicine, January 27.

The physicians appearing on **"All About Baby"** are scheduled by the **Educational Committee of the Illinois State Medical Society**. The telecast is produced by the Herbert Laufman Television Productions and is sponsored by the Libby Foods, Swift Meats and Toni Companies.

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## DEATHS

Joseph R. Allen, Urbana, who graduated at Barnes Medical College, St. Louis, in 1898, died October 24, aged 80.

Louis L. Beehler, Chicago, who graduated at Northwestern University Medical School in 1900, died November 7, aged 75.

Samuel Philip Colehour, Mount Carroll, who graduated at National Medical College, Chicago, in 1899, died August 10, aged 77. He was a member of the Illinois State Medical Society.

Benjamin A. Cottlow, Oregon, who graduated at the Hahnemann Medical College and Hospital in 1892, died December 15, aged 82.

Robert E. Cummings, retired, Chicago, who graduated at Loyola University School of Medicine in 1924, died December 13, in Winter Park, Florida, aged 65. He was a member of the Illinois State Medical Society, the American Academy of Pediatrics, and formerly assistant clinical professor of pediatrics at Stritch School of Medicine of Loyola University.

Albert Wilson Dowson, Evanston, who graduated at Jenner Medical College in 1915, died August 11, aged 59, of coronary sclerosis.

Irving J. Eales, Chicago, who graduated at the Col-

lege of Medicine and Surgery, Chicago, in 1903, died December 23, aged 93.

Ernest A. Fetherston, Winnetka, formerly of Monmouth, who graduated at Northwestern University Medical School in 1899, died January 5, in Flower Hospital, Toledo, Ohio, aged 80. He was a member of the Illinois State Medical Society.

Paul Hertel, Chicago, who graduated at Bennett Medical College in 1915, died in the Alexian Brothers' Hospital, November 18, aged 75.

Alva Hiatt, Monmouth, who graduated at the College of Physicians and Surgeons of Chicago, School of Medicine of the University of Illinois, in 1905, died December 9, aged 77. He was a member of the Illinois State Medical Society.

Martin J. Ives, Joliet, who graduated at Rush Medical College in 1904, died September, aged 74. He was a member of the Illinois State Medical Society.

Edward James Lewis, Chicago, who graduated at Rush Medical College, died November 25, aged 67, of coronary thrombosis and cerebral thrombosis. He was a member of the Illinois State Medical Society and formerly a member of the faculty of Rush Medical College.

Benjamin V. McClanahan, Galesburg, who graduated at the University of Illinois College of Medicine in 1915, died November 17, aged 61, of cerebral hemorrhage. He was affiliated with Galesburg Cottage and St. Mary's Hospital, and was a member of the Illinois State Medical Society.

Fred E. Miller, Lawrenceville, who graduated at Chicago College of Medicine and Surgery in 1916, died August 24, aged 72.

Frederick Tice, Chicago, who graduated at Rush Medical College in 1894, died December 18, aged 82, of cardiac decompensation and arteriosclerotic heart disease. He was professor of medicine and head of the department at the University of Illinois College of Medicine and former president of the Municipal Tuberculosis Sanitarium Board, and a member of the Illinois State Medical Society.

Harry John Toomajan, Grayslake, who graduated at Loyola University School of Medicine in 1926, died November 11, aged 55, of carcinoma of the left lung. He was a member of the Illinois State Medical Society and affiliated with St. Therese's Hospital and Lake County General Hospital in Waukegan.

Roy D. Williams, Antioch, who graduated at Northwestern University Medical School in 1900, died December 13, aged 78. He was Antioch's health officer.

Rollin Turner Woodyatt, Chicago, who graduated at Rush Medical College in 1902, died December 17, aged 74. He was clinical professor of medicine emeritus at (Rush University of Illinois College of Medicine, honorary president of the Chicago Diabetes Association, past president of the Association of American Physicians and the American Society for Clinical Investigation, and a member of the Illinois State Medical Society.

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## REHABILITATION

The reason rehabilitation encompasses such a broad field of endeavor is that the solution of the complex problems of the disabled individual is accomplished by a team of workers. The various disciplines — medicine, psychology, sociology, and economics — are brought together in the physician; the nurse; the physical, speech, and occupational therapist; the social worker; the psychologist; the vocational coun-

selor; and others, in order to focus on the individual as a whole in terms of his total environment and total problems. Thus one sees that rehabilitation is concerned with the whole man. His whole life — physical, social, mental, vocational, and economic — is important and true rehabilitation is concerned with each phase separately and with the unified whole which makes him what he is. *Harold N. Neu, M.D., Rehabilitation: The Third Phase of Medical Care. Nebraska M.J., Sept. 1953.*

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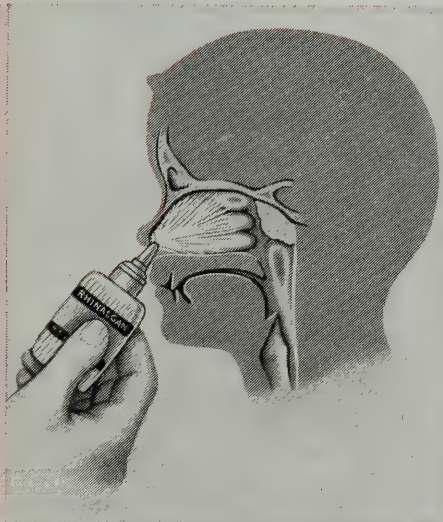
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# BOOK REVIEWS



**WATER, ELECTROLYTE AND ACID-BASE BALANCE.** Harry F. Weisberg, M.D., Assistant Professor of Clinical Pathology and Clinical Medicine, The Chicago Medical School. Williams & Wilkins Co., Baltimore, 1953. \$5.00.

This popular and frequently difficult subject is treated in three main sections, "Normal Physiology", "Pathologic Physiology", and "Therapeutic Guideposts". The section on normal physiology is incomparable for the basic, logical, and concise manner in which fundamental concepts are presented. Data are included and statements are documented from the widely scattered current literature as well as from standard works of medicine, physiology, and biochemistry. The many tables bring together useful data in a form which should prove valuable for frequent clinical reference. Dehydration, acidosis, alkylolysis, and abnormalities involving the different electrolytes are considered under pathologic physiology. Conditions which may result in such alterations are covered in an encyclopedic fashion. The section on therapy does not quite achieve the high standards of prior sections, but is nonetheless very useful in practical clinical problems. Notable features include a detailed discussion of electrolyte repair solutions and a compendium of therapy giving step-by-step management in a hypothetical patient with severe fluid and electrolyte imbalance. The table of contents, lists of tables and figures, index, and bibliography are well worked out so that easy reference may be made to any subject included. This 245 page book can be recommended without reservation to all students of medicine and to all practitioners who are called upon to give parenteral therapy for the prevention or correction of fluid and electrolyte imbalance.

W. R. B.

## BOOKS RECEIVED

The following books have been received for reviewing, and are herewith acknowledged. This listing should be considered as a sufficient return for the courtesy of the sender. Books that appear to be of unusual interest will be reviewed as space permits each month. Readers desiring additional information relative to books listed, may write the Editor who will gladly furnish same promptly.

**TEXTBOOK OF PHYSIOLOGY AND BIOCHEMISTRY.** By George H. Bell, G.Sc., M.D. (Glasg.), F.R.F.P.-S.G., F.R.S.E., Professor of Physiology in the University of St. Andrews at University College, Dundee, and J. Norman Davidson, M.D., D.Sc. (Edin.), F.R.F.P.S.G., F.R.I.C., F.R.S.E., Gardiner Professor of Physiological Chemistry in the University of Glasgow, and Harold Scarborough, M.D., Ph.D. (Edin.), F.R.C.P.E., Professor of Medicine in the Welsh National School of Medicine of the University of Wales and Director of the Medical Unit in the Royal Infirmary, Cardiff. With a foreword by Robert C. Garry, M.B., D.Sc. (Glasg.), F.R.F.P.S.G., F.R.S.E., Regius Professor of Physiology in the University of Glasgow. Second edition. E. & S. Livingstone LTD. Edinburgh and London, 1953. 1002 pages. \$10.00.

**SCHOOL HEALTH SERVICES.** A Report of the Joint Committee on Health Problems in Education of the National Education Association and the American Medical Association with the cooperation of contributors and consultants. Charles C. Wilson, M.D., Professor of Education and Public Health, Yale University, Editor. National Education Association and American Medical Association, 486 pages. \$5.00.

(Continued on page 60)

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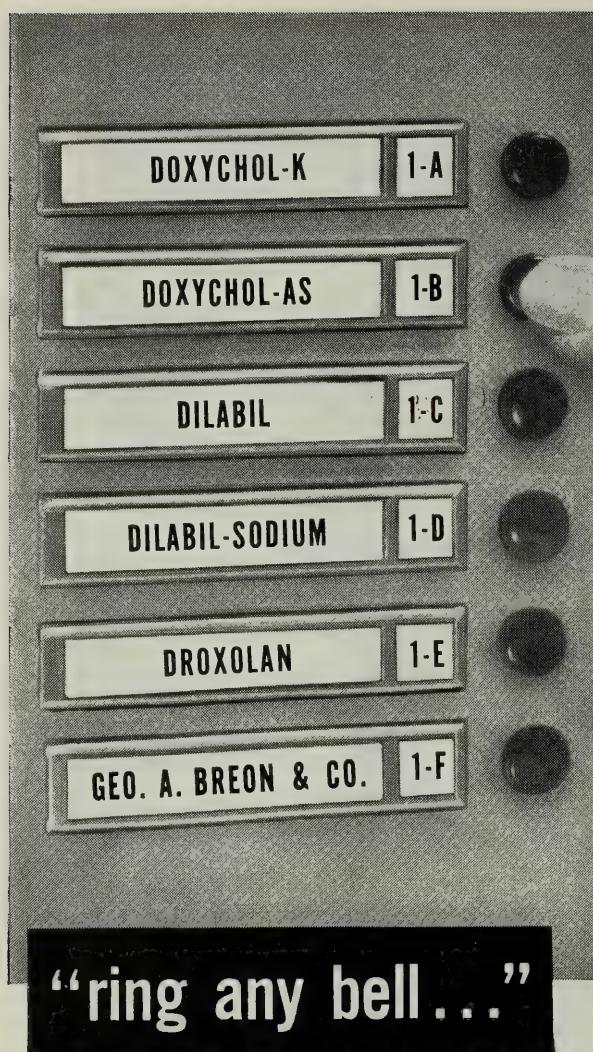
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## BOOKS RECEIVED (Continued)

**AN APPROACH TO GENERAL PRACTICE.** By R. J. F. H. Pinsent, M.A., M.D. (Cantab.) With a foreword by Sir Lionel Whitby, C.V.O., M.C., Regius Professor of Physics, University of Cambridge. E. & S. Livingstone LTD., Edinburgh and London, 1953. 166 pages. Science and Man's Behavior—The Contribution of Phylobiology. By Trigant Burrow, M.D., Ph.D. Edited by William E. Galt, Ph.D. Including the complete text of *The Neurosis of Man*. Philosophical Library, New York. 564 pages. \$6.00.

**THE RELATION OF LEAN BODY WEIGHT TO METABOLISM AND SOME CONSEQUENT SYSTEMATIZATIONS.** By Albert R. Behnke, Captain, Medical Corps, U. S. Navy. 48 pages, illustrated. \$1.25.

**GROWTH OF PROTOZOA.** By S. H. Hutner and 52 other authors. *Annals of the New York Academy of Sciences*. Volume 56, Art. 5. 280 pages, illustrated. \$4.50.

Isoniazid is unquestionably a very potent drug, but the striking degree of immediate improvement which follows the use of this agent is not a measure of its worth in the treatment of tuberculosis. It should not be forgotten that, in tuberculosis, antibacterial agents, at best, enhance natural processes of healing. Sooner or later the tubercle bacillus acquires resistance, and the disease resumes its preordained course, depending on factors beyond the reach of therapeutic weapons. Eli R. Rubin, M.D., N.Y.S. J. of Med., June 15, 1953.

## CULDOSCOPY

In 1942, Decker was able to visualize the entire pelvis in a patient by inserting the instrument (Culdoscope) with the patient in the knee-chest position; these observations were not reported until 1944. By utilizing the negative intra-abdominal pressure created by placing the patient in the knee-chest position, Decker has introduced a practical means of visualization of the pelvic organs per vagina. The pelvic organs are surrounded by air and the intestines fall out of the pelvis toward the diaphragm. The negative pressure created within the abdominal cavity with the patient in the knee-chest position is of the magnitude of minus 10 to minus 18 cm. of water. The pneumoperitoneum which follows perforation of the vagina with the patient in this position is from 600 to 1,800 cc. *Leslie C. Colwell, M.D., M.Sc. (Med.), Austin, Texas, Culdoscopy, A Plea for More Widespread Application. Texas State J.M., November, 1953.*



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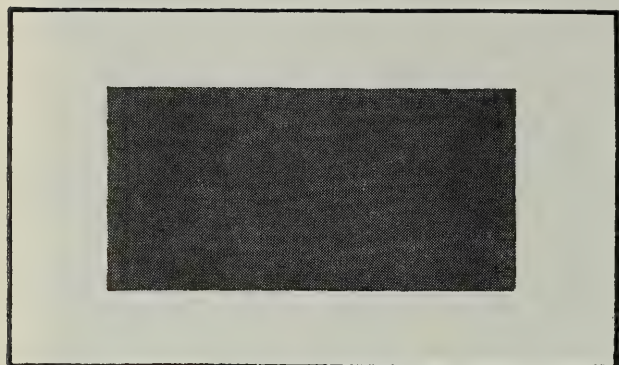
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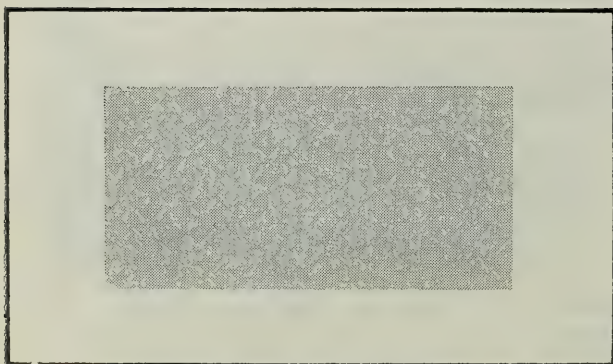
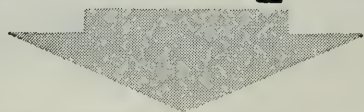
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3. Disregard of pathologic conditions of the stump such as tender scar or neuroma.
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5. Use of mechanical gadgets that were ungainly, unsightly, poorly adapted, and unrealistic.
6. Cosmetic dissatisfaction.

7. The greatest source for failure has been mechanical and function failures of the prosthesis so that the prosthesis became a burden to the patient. *Jerome Lawrence, M.D., Brooklyn, N. Y., Management of the Upper Extremity Amputee. N. Y. State J.M., November 15, 1953.*

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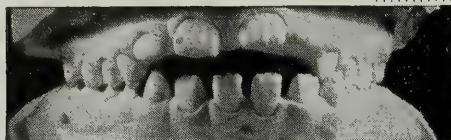
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## SHRUNKEN HUMAN HEADS

One may wonder sometimes at the articles displayed in what is supposedly a medical museum, and the question often has been asked why two shrunken heads, or tsantsa, prepared by the Jibaro tribes of Ecuador and Peru are part of the Mütter Museum collection of the College of Physicians. The head was regarded as the most important organ of the body by primitive peoples and in ancient times cures for many ailments were applied to it. So it is not strange when objects of worship, magic articles to ward off evil and to increase wealth and power, and war trophies were desired, the head was chosen.

The entire process of shrinking the head is not known but it begins with the separation of the scalp and the skin of the face from the skull. The skull is discarded and the parts removed left in boiling water for a while. The reduction is accomplished by rolling hot stones to and fro within the head, followed by hot sand which is distributed uniformly by keeping the head in motion. During the treatment the features are molded with the fingers and the head finally blackened with charcoal. Although the Jibaro head hunter has obtained a magic object, his triumph is mixed with the fear of dire consequences for killing and mutilating his enemy, and he is considered unclean. To defend his family and himself against the revenge that might be visited upon them by the spirit of his former foe, he must go through a purifying ceremony which lasts two years. *Ella N. Wade. Shrunken Human Heads. Philadelphia Med., Sept. 12, 1953.*

Health departments have traditionally worked with the full cooperation of the medical profession. The family physician is the front line of any public health endeavor. In order for a community health program to succeed the practitioner must give full cooperation and active rather than passive support. Experience has shown that the more extensive the public health program a community enjoys, the greater the demand made by the public on services not only for the treatment of illness but also for health supervision and for preventive services. *Vlado A. Getting, M.D., J.A.M.A., Sept. 26, 1953.*

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## CHILDHOOD DIABETES

I know of no case on record of a child born with diabetes, yet there are reported cases of onset at nine weeks and thereafter. It is difficult to estimate the number of juvenile diabetics in this country. The National Health Survey revealed that under age 15, one child in 2500 has diabetes. Joslin suspects that there are 60,000 diabetics now living whose disease began in childhood—this would seem conservative.

Sir William Osler in his textbook of 1892 stated: "In children the disease (diabetes) is rapidly progressive, and may prove fatal in a few days." This was literally true before the days of insulin, and is still true unless informed parents recognize early symptoms and astute doctors make an early diagnosis and institute therapy immediately. Childhood diabetes proceeds invariably to acidosis, coma, and death within from three to twelve months unless treated with insulin. *Edwin L. Rippey, M.D., Dallas, Texas, Diabetes in Childhood. J. Louisiana State M. Society, November, 1953.*

## GAMMA GLOBULIN IN MUMPS

Twelve cases of mumps meningoencephalitis with one death (a mortality rate of 8 per cent for the year) were seen during 1952 at Kingston Avenue Hospital, the communicable disease hospital for the nearly three million people of the Borough of Brooklyn. By comparison, there were 30 cases with central nervous system complications caused by measles with four deaths. Many of these measles encephalitis and encephalomyelitis cases were treated with gamma globulin and adjunctive therapy. It was observed that the best results were obtained in a group of 15 critically ill patients who received a total dosage of from 0.5 to 1.1 cc. of gamma globulin per pound of body weight, provided that the gamma globulin injections and adjunctive therapy were started as soon as the signs and symptoms of central nervous system complications appeared. *Louis Odessky, M.D., Irwin Schiff, M.D., Irving J. Sands, M.D., and David Spielsinger, M.D., Brooklyn, New York, Mumps Meningoencephalitis Treated with Gamma Globulin. N.Y. State J.M., November 15, 1953.*

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The infant formula product manufacturer and the medical profession are both highly conscious of the importance of public relations at all operating levels. Latest evidence of this is the series of test advertisements appearing in the Illinois State Medical Journal in which The Borden Company's Prescription Products Division salutes the medical profession in selected Illinois cities. General response to these ads in this journal, one of four state journals selected for the test, has prompted the company to extend the ad campaign.

Through this medium, Borden's hails the newborn babies of these selected cities and the physicians, hospitals and pharmacies which bring them the high standards of American medicine. This Borden division produces and ethically promotes three infant formula products.

Institutional in character, the advertising copy points up the community aspect of the national organization. The Borden name has a 100-year history in the field of infant feeding, since it was in 1853 that the company's founder, Gail Borden, originated preserved milk to provide safe nutrition for babies.

With the current February issue of the Journal, the five Illinois cities featured to date include Rockford, Peoria, Decatur, E. St. Louis and Joliet. Springfield will be saluted in the next issue of the Journal.

Cooperative clinical research as applied to problems of tuberculosis therapy has been so eminently successful, regardless of the sponsoring agency, that other fields of clinical research should take more cognizance of this as a means to advance knowledge. While similar end results would eventually appear from more conventional studies, the time required to ascertain the truth would be greatly prolonged. H. Corwin Hinshaw, M.D., Am. Rev. Tuberc., Aug., 1953.

Too much should not be expected from general population chest roentgenographic surveys. Certainly, many patients are diagnosed through surveys as having progressive disease. Placing them under medical supervision promptly may prolong or even save life. But "early diagnosis" is not synonymous with minimal disease and prevalence is far from synonymous with incidence. Analysis of the morbidity and mortality subsequent to original diagnosis is the test of the contribution mass chest roentgenographic surveys made to the tuberculosis case-finding program. Wendell R. Ames, M.D., and Miller H. Schuck, M.D., Am. Rev. Tuberc., July, 1953.

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still alive and normal one week after biting; merely to satisfy the anxiety of parents or family but otherwise not indicated; and for persons previously treated, the vaccine retreatment, if used at all, should be limited to not more than six doses. *Ben F. Wyman, M.D., Rabies and the Doctor. South. Gen. Pract., Oct. 1953.*

Health is everybody's business. Optimal health is not an inalienable right and privilege of the individual that comes automatically. The health of the individual must be actively worked for, and the health of the community must be carefully planned, developed, and nurtured. The health program must consider the entire community. *Vlado A. Getting, M.D., J.A.M.A., Sept. 26, 1953.*

Among patients admitted to general hospitals, the prevalence of definite and suspected tuberculosis and of probably active tuberculosis is twice as high as among individuals X-rayed in mass surveys. Thus 14 (1.4 per cent) of every 1,000 patients show on admission X-ray the presence of definite or suspected tuberculosis as against seven for every 1,000 in mass surveys. Two of every 1,000 X-rayed on admission to general hospitals show probably active tuberculosis as against one for mass surveys. *N.Y.S. Dept. of Health, Div. of TB Control, 1952 Annual Report.*



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## A DIFFERENT APPROACH TO FOOD POISONING

Salmonellosis is a particularly interesting bacterial disease of animals which affects many animal species and birds. It is normally spread to man by means of ingestion of the organism. One way in which this spread occurs is by eating eggs or meat from infected animals or poultry which have not been cooked sufficiently to kill the organisms. It should be noted, however, that in many instances epidemiological investigations have revealed that although the *Salmonella* organism originated in either chicken or a piece of meat, the actual human ingestion occurred by way of cooked shrimp or luncheon meat. In most supermarkets, cooked shrimp or sliced luncheon meat, which is not treated further at home, is purchased at the same counter where cut-up frying chickens are displayed. The counter man who cleans and serves the chicken usually is the same person who serves the shrimp and luncheon meats. His hands are many times severely contaminated with *Salmonella* organisms from a bird that he has cleaned, but which has no recognizable symp-

toms of the disease. The chicken is thoroughly cooked; the shrimp and luncheon meats are not. The disease is thus transmitted by the mishandled shrimp or luncheon meat. It also has been found that the housewife brought home a chicken or some meat, placed it on a drain-board, and then properly cooked the meat or chicken. But then she proceeded, after a cursory washing of the board, to clean celery, lettuce, and other items which were to be eaten raw. One can readily see that this is an instance in which an animal disease is transmitted to human beings via the contamination of other foods. *Oscar Sussman, D.V.M., Animal Diseases Transmissible to Man. Am. J. Pub. Health, Nov. 1953.*

Tuberculosis patients with long-established chronic disease who circulate and act as sources of infection in the community represent a serious situation everywhere. As life is saved or prolonged by treatment, the death rate drops but the number of living patients continues to be high, and in fact, rises in some groups, particularly elderly men. *J. Burns Amberson, M.D., Pub. Health Reports, Oct., 1953.*

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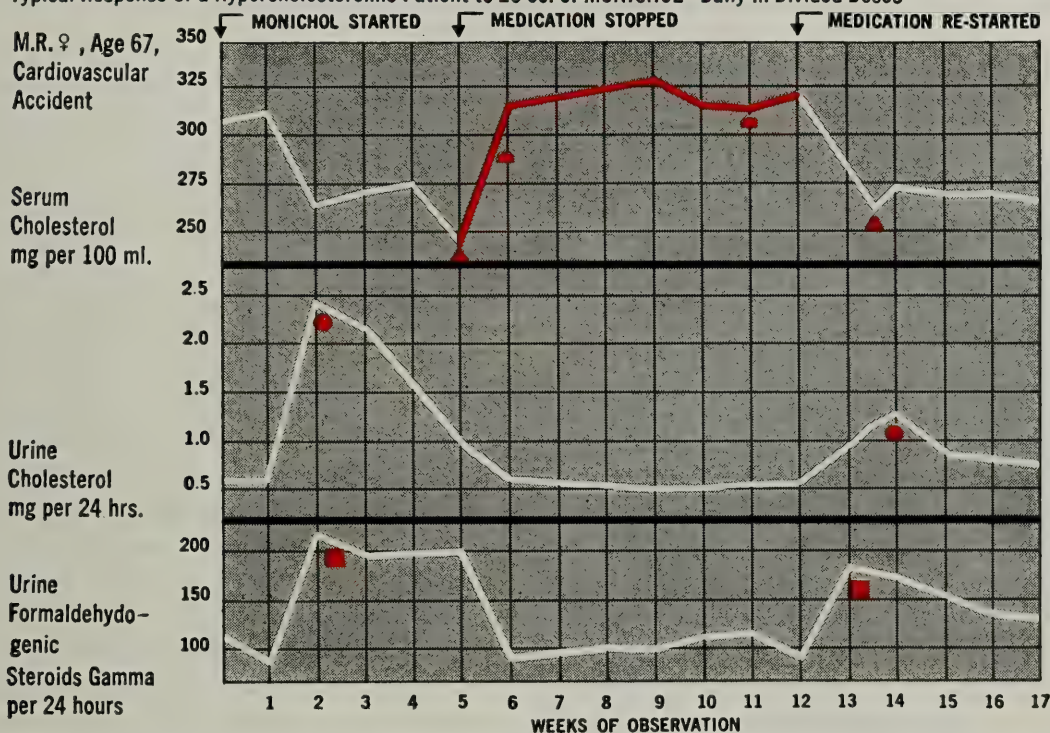
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\*\*Sherber, D. A., and Levites, M. M.: Hypercholesteremia. Effect on Cholesterol Metabolism of a Polysorbate 80-Choline-Inositol Complex (MONICHOL) J.A.M.A. 152:682 (June 20) 1953.

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injury to the public would result in a particular instance. . . ." The court continued with this significant statement, "The test to be applied is not what is actually done but that which may or might be done under the terms of the contract; it is the evil tendency of the contract and not its actual injury to the public that is determinative. The law looks to its general tendency and closes the door to temptation by refusing to recognize such agreements." *Editorial, Evil Tendency. Norfolk Med. News, Oct. 1953.*

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1. Sayer, R. J., et al.: Am. J. M. Sc. 221:256 (Mar.) 1951.

2. Welch, H.: Ann. New York Acad. Sc. 53:253 (Sept.) 1950.

3. Werner, C. A., et al.: Proc. Soc. Exper. Biol. & Med. 74:261 (June) 1950.

4. Wolman, B., et al.: Brit. M. J. 1:419 (Feb. 23) 1952.

5. Potterfield, T. G., et al.: J. Philadelphia Gen. Hosp. 2:6 (Jan.) 1951.

6. King, E. Q., et al.: J. A. M. A. 143:1 (May 6) 1950.

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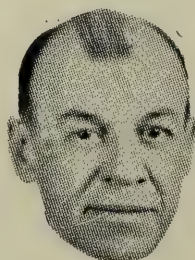
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plying the abrasive balloon and papaine solutions, have been developed to a very high degree of accuracy and may very well clinch the diagnosis before surgery. *Lewis W. Guiss, M.D., Los Angeles, Calif., Cancer of the Stomach, Arizona Medicine, January, 1954.*

## NERVOUS BLADDERS

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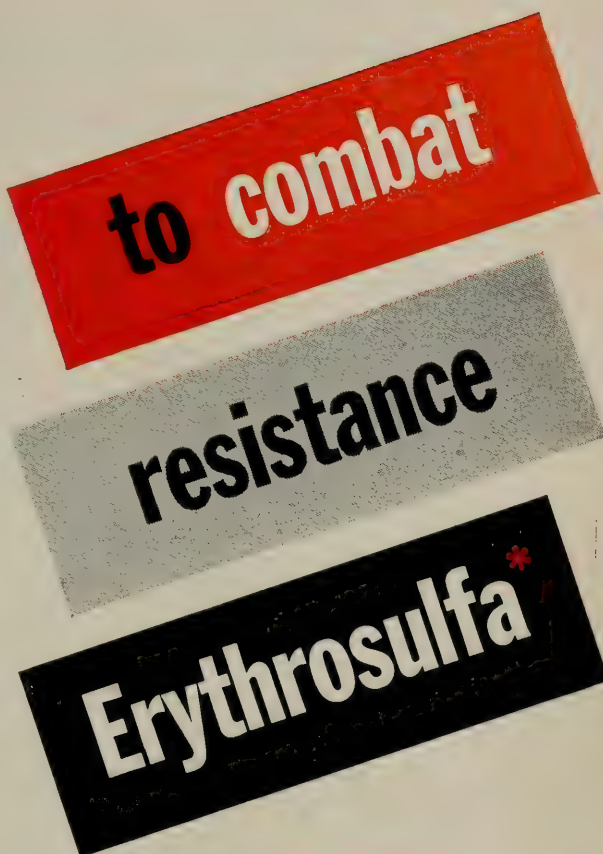
Examination of mortality and morbidity data leads to the conclusion that malaria and tuberculosis were the outstanding disease problems in Latin America during the decade 1942-52. Such diseases as yaws, hookworm disease, Hansen's disease, schistosomiasis, and epidemic typhus, however, also constituted problems, and in some areas one or another of these rivaled malaria and tuberculosis for a top-ranking position. Institute of Inter-American Affairs, Pub. Health Reports, Nov., 1953.

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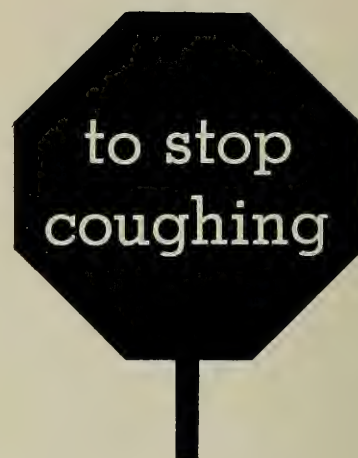
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1. Segal, M.S., et al.: Advances in the Physiology and Treatment of Bronchial Asthma, Quart. Rev. Allergy & Applied Immunology 6:399 (December) 1952.

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# *The* ILLINOIS *Medical Journal*

Official Journal of the Illinois State Medical Society

Harold M. Camp, EDITOR.

Theodore R. Van Dellen, ASSOCIATE EDITOR.

Vol. 105, No. 3

March, 1954

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## Correction of Congenital Anomalies of the Ear

Eugene L. Derlacki, M.D. and George E. Shambaugh, Jr., M.D.  
Chicago

The surgical correction of developmental anomalies of the sound conducting apparatus is a relatively new operative procedure in the growing field of temporal bone surgery. The main impetus in the development of reconstructive surgery in congenital anomalies was derived from the reports of Pattee<sup>1</sup> and Ombredanne<sup>2</sup> in 1947. Subsequent articles by these authors<sup>3,4</sup> and by others<sup>5, 6, 7</sup> including the original report of our own series by one<sup>8</sup> of us, has added considerably to the literature on the subject.

The prevailing emphasis in these reports has been upon a single technic by each author leaving a doubt as to the best procedure for this surgery. The emphasis in this movie presentation is upon the embryologic development of the ear in order to understand the possible anomalies of the ear that may be encountered and to deal with them specifically and effectively.

The particular anomaly in each case varies considerably, and no one technic can be suitable for all cases. Thus, in each case the surgical procedure should be fitted to the condition that is found, keeping in mind that the aim is to construct a sound conducting system that will most nearly approach the normal impedance-matching mechanism.

Since the two principal divisions of the organ of hearing come from different embryonic anlagen, there is a marked tendency for anomalies

of the inner ear to be independent of anomalies of the outer and middle ear. Of the 26 ears with developmental anomalies of the sound conducting apparatus operated by us, 21 had normal cochlear function, 2 certainly had a cochlear defect, presumably developmental, and 3 probably had a cochlear defect, but were still too young to permit reliable bone conduction testing.

Congenital anomalies of the sound conducting apparatus occur during the second to the seventh month of foetal life, the particular deformity in each case depending upon the age of arrested development and the area of the gill structures chiefly involved.

We prefer the atticotomy approach, as used in fenestration surgery, to minimize the risk of injury to the facial nerve in those cases with a much reduced or even absent antrum, attic and tympanic cavity.

As soon as the attic and middle ear are exposed by the atticotomy approach, the type and extent of the anomaly is determined by careful inspection under magnification, and the appropriate corrective procedure is selected, aiming to construct a sound conducting apparatus that will most nearly approach the normal in its impedance-matching action.

*Results Of Surgical Correction Of Congenital Anomalies Of The Ear.* — Of the 26 ears we have operated 1 consisted of a facial nerve repair of a case unsuccessfully operated elsewhere, and in 1 case the operation was terminated when the attic was not found. Of the 24 operations com-

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Presented before the Illinois State Medical Society,  
Section on Eye, Ear, Nose and Throat, 113th Annual  
Meeting, May 19, 1953.

Table 1.

Case	Ear	Age at Op.	Meatus	M.T.	Malleus & Incus	Stapes	Surgical Procedure	Cochlear Function	Pre-op Loss (512, 1024, 2048)	Last Post-op Test	
										DB Loss	Time Post-Op.
1 B	L	7	Atresia	Normal	Normal	Normal	Cr. Meat. with Graft	Normal	56 db	18 db	5 years
	R	7	Atresia	Normal	Normal	Normal	Cr. Meat. with Graft	Normal	50 db	17 db	5 years
2 B	R	7	Patent	Normal	Normal	Immobile	Fenestration	Normal	52 db	23 db	3½ years
	L	10	Patent	Normal	Normal	Immobile	Fenestration	Normal	58 db	28 db	1 year
3 B	R	6	Facial Nerve Repair		.....	.....	.....	.....	62 db	.....	.....
4 B	R	4	Atresia	Present	Sl. Def.	Normal	Cr. Meat. with Graft	? Imp.	?	50 db	4 years
	L	5	Atresia	V. Thick	Def.	Normal	Cr. Meat. with Graft	? Imp.	?	48 db	3 years
5 B	L	7	Narrow	Normal	Sl. Def.	Def.	Fenestration	Normal	59 db	23 db	3 years
	R	10	Narrow	Large	Cholesteatoma	inv. M.E.	Enlarg. Meat.	Normal	60 db	42 db	3 months
6 U	R	18	Atresia	Absent	Normal	Normal	Cr. Meat. with Graft	Normal	55 db	25 db	2½ years
7 B	L	15	Atresia	Absent	Def.	Normal	Cr. Meat. with Graft, Ossic., Fenes.	Imp.	97 db	77 db	2½ years
8 U	R	22	Atresia	Absent	Def.	Normal	Cr. Meat. with Graft, Ossic., Fenes.	Imp.	95 db	75 db	3¼ years
9 U	L	13	Atresia	Absent	Normal	Normal	Cr. Meat. with Graft, Revised 3 mos. Graft	Normal	58 db	23 db	2½ years
10 U	L	24	Atresia	Small	Normal	Normal	Cr. Meat. with Graft	Normal	36 db	3 db	2 years
11 B	R	25	Normal	Normal	Normal	Immobile	Fenestration	Normal	47 db	17 db	20 mos.
12 B	L	25	Atresia	Absent	Def.	Normal	Cr. Meat. with Graft, Ossic.	Normal	68 db	28 db	1½ years
13 U	L	5	Atresia	Absent	Def.	Normal	Cr. Meat. with Graft, Revised with Ossic.	? Imp.	785 db	50 db	2 years
14 U	R	9	Atresia	Absent	Def.	Normal	Cr. Meat. with Graft, Ossic.	Normal	73 db	17 db	1 year
15 B	R	14	Normal	Normal	Normal	Immobile	Fenestration	Normal	48 db	42 db	1 year
16 U	R	17	Atresia	Antrum & Attic not found			Op. not completed	Normal	75 db	.....	.....
17 B	L	11	Atresia	Absent	Sl. Def.	Normal	Cr. Meat. with Graft	Normal	41 db	42 db	9 months
18 B	R	4½	Atresia	Absent	Def.	Normal	Cr. Meat. with Graft, Ossic.	Normal	53 db	32 db	1½ years
19 U	R	5	Atresia	Absent	Def.	Normal	Cr. Meat. with Graft, Ossic.	Normal	63 db	35 db	6 months
20 U	R	5½	Atresia	Absent	Def.	Normal	Cr. Meat. with Graft	Normal	61 db	50 db	8 months
21 U	R	17	Atresia	Absent	Def.	Normal	Cr. Meat. with Graft, Ossic.	Normal	74 db	30 db	4 months
22 U	L	32	Atresia	Absent	Sl. Def.	Normal	Cr. Meat. with Graft, Ossic.	Normal	49 db	27 db	2 months

pleted for improvement of the hearing, all received an initial hearing gain. In 3 the gain was not maintained: 1 was lost due to osseous closure of the fenestra in the semicircular canal, 2 were lost due to fibrosis fixing the ossicles. Of the 21 ears with maintained hearing improvements, 2 were revised with skin grafting of the meatus after a secondary atresia, 1 was revised with removal of the incus and malleus due to secondary fibrosis and fixation. These cases regained their improvement and have maintained it.

Of the 26 operated ears with an anomaly of the sound conducting apparatus, 19 had an atresia, 5 of these with a formed tympanic membrane, 14 with a bony plate replacing the tympanic membrane. In 14 of the 26 ears the malleus and incus were malformed (Meckel's cartilage), in 5 the stapes was deformed (Reichert's cartilage).

Of the 21 ears with maintained improvement in hearing, 13 are at the practical 30 db level

or better at the most recent test, 9 of these having maintained this result for 2 years or longer; 5 of the ears below the practical level have a cochlear impairment restricting the level attained.

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## A POSSIBLE CAUSE FOR CANCER

There is as yet no definite evidence proving a relationship of viruses to human cancer. The nearest approach is the announcement by Gregory of the finding, under the electron microscope, of globoid virus-like bodies in 100 per cent of human cancers, and their absence in nonmalignant tumors. Hellwig reports somewhat similar results but with the finding of somewhat similar, though smaller bodies in benign lesions. Unlike Gregory, Hellwig re-

gards these simply as globular proteins. Of the viruses which have been studied in detail, that of Rous would appear to have no possible relationship to human cancer. The Shope virus, with all the indications of an actively infectious agent, offers a close analogy to the virus which, in the human, causes the common wart; one is tempted to speculate whether, among the several races of man, there is one in which the wart virus would be carcinogenic. *H. E. Eggers, M.D., Viruses as a Cause of Cancer. Nebraska M. J., Sept. 1953.*

# Vaginal Plastic Operations

Newton DuPuy, M.D.  
Quincy

Fourteen years ago at White Sulphur Springs, I presented a paper on this subject. This occasioned quite a fight among the older specialists. Today I am more firmly convinced of the advisability of these procedures. I should like to say here that, in addition to the post-partum patients at term, I also include those patients who have had clean accidents of pregnancy causing premature labor. In fact we very frequently find these accidents of pregnancy resulting from old injuries of the birth canal. The patient may have been urged to have an interval repair, but pregnancy often occurs before she could "get around to having the operation." Thus the patient is a candidate for endless repetition experiencing the discomfort of her injured genital tract as well as the hazards of subsequent pregnancies.

Elective vaginal operative procedures immediately following delivery have long been vigorously opposed. It has only been in the past eighteen to twenty years that we have found a few progressive obstetricians who would countenance these repairs. However, as early as 1906, Dr. F. H. Stuart of Brooklyn advocated immediate repairs of the birth canal and in 1916 Dr. J. L. Bubis of Cleveland performed an extensive gynecoplasty on a forty year old patient who had had ten children. His courage in performing a trachelorrhaphy, colporrhaphy, both anterior and posterior, as well as a hemorrhoidectomy, was shockingly radical but the patient's uneventful recovery and good end-results served to initiate a series of several thousand cases which followed this patient through his Clinic. His summarized results clearly show the very distinct advantage of this practice.

In 1936, as resident in obstetrics for Dr. Louis H. Douglass of Baltimore, I was encouraged to do *only* central episiotomies; trachelorrhaphies, later perineoplasties, and still later, anterior colporrhaphies.

Occasionally a physician will advocate the patient returning when her baby is six months old for these operations. However, the majority of women will not return to the hospital for various reasons, principle among them being economic conditions, domestic obligations and timidity. Often the family physician is at fault, having advised a patient to wait until after her reproductive period before having necessary birth canal corrections with the argument that subsequent pregnancies will merely destroy the results of any operation. Thus the patient is subjected to needless years of discomfort, if not actual pain. Estranged wives have often attributed their marital difficulties to an unhappy sex relation following injuries occasioned by childbirth.

There is one fact I would especially emphasize and that is the universally good results that have been obtained from the very beginning and in the hands of almost all operators. This can be attributed to several things. First, one might say that *nature is more in the mood for repair* since normal restitution is going forward with involution of the uterus and it is part of mother nature's duty at this time to return the pelvic organs and adjacent tissues to a normal state. When we can facilitate this by removing chronic torn and scarred tissues we are relieving, in some measure, mother nature's burden at this time. Certainly another point in favor of better healing is the greater elasticity of the tissues so that there is less tension on the repaired parts. Some physicians will advance the argument that the edematous condition of the tissues prevents proper delineation and coaptation. This, however, is merely a matter of skill and judgment. The danger of infection has often been used as an argument against these elective procedures and although this is a controversial subject it seems that the pelvic regions, particularly the vagina and vulva, are more resistant. We have all had the experience of treating a third degree laceration of the perineum and in spite of fecal contamination we have watched healing per primum.

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We know, also, that a patient's general health is better during pregnancy than at any other time of her life. Those specialists who pioneered in this work noted that patients repaired immediately post-partum made a quicker recovery than those repaired three, six or eight months after delivery. I would like to say again — to stress this point — that trachelorrhaphies and perineorrhaphies done immediately post-partum are better than the same repairs done at any other time.

These operations are reserved for selected cases which have had proper prenatal care and an explanation of the intended repair, as it would be almost impossible to determine immediately after delivery whether or not a patient would have a cystocele or rectocele at her six week's or six month's checkup. During the patient's pregnancy we make a practice of treating any local infection of this region so that we may have as clean an operative field as possible.

At this point let me digress for a moment to mention analgesia and anesthesia. The common barbiturates are used in early labor, followed with small repeated doses of demoral and scopolamine. At the time of actual delivery a pudendal block is done employing 1% procaine with 1 to 1000 epinephrine and wydase (150 T R units). Local infiltration, using the same solution, is helpful for fluid dissection (i. e. elevation) of the mucous membrane. If the patient should require further anesthesia we are using the Duke inhalator with trilene.

I should like to take another moment to talk about our obstetrical and gynecological "prep". Patients on admission are shaved and bathed with soap and warm water. Nurses wear gloves and use flats of gauze. Repeat scrubs are done if catheterization is necessary or when examinations are made. A final thorough soap scrub is done when the patient is "put up" for delivery. Incidentally the same method is used even for Caesarean preps. We have followed these practices for about two years and have noted no increased morbidity; no failure of wound healing. We avoid post-operative dressings as much as possible.

If the patient's labor has been without mishap and her immediate post-partum condition is good, our procedure is briefly as follows. At the time of delivery, as the baby's shoulder is born, intravenous pitocin ( $\frac{1}{2}$  cc) is administered

so that the placenta usually follows the baby or is expressed shortly thereafter. Intramuscular ergotrate is then given and we thus have a dry field in which to do the operations. A careful examination of the cervix is then made. For this purpose we employ five sponge sticks. Using an anterior and posterior retractor, the vaginal vault can be easily visualized and the cervix brought down gently, any fresh laceration, no matter how small, is repaired. We commonly employ double zero chromic catgut using interrupted figure of eight sutures. Old scars are excised and repaired, care being taken to suture the angle. The sutures should be tied loosely.

Unfortunately some of these operations will not heal by first intention, but the majority will, and at the time of the six weeks' examination the external os will present an almost nulliparous appearance and not the usual transverse slit of a multipara. This familiarity with the cervix leads to a proficiency which is helpful when a repair is necessary because of bleeding. It also makes one feel safer when it becomes necessary to do the rare, but occasional, hysterostomy. You have, no doubt, occasionally been confronted with a premature labor and the baby presenting as a breech. The buttocks and even the shoulders will come through a cervix that will not admit passage of the premature baby's head and if one is to salvage the baby it sometimes becomes necessary to make Duhrssen's incisions. The old argument that scar tissue forms in these repair lines is incorrect, and experience will teach that this theory is entirely imagined.

Colporrhaphy, both anterior and posterior, is simply done, the mucous membrane being elevated by fluid dissection. For this purpose we use the procaine solution mentioned above. Any excess of mucous membrane is excised. The fascial edges are then approximated and, of course, any muscle group is returned to its normal position. We use interrupted sutures of zero and double zero chromic catgut. The mucous membrane is closed with a continuous suture. Skin edges are closed with a subcuticular stitch. Care must be taken to see that sutures are not placed too tightly since this may cause sloughing. We do not believe in the use of skin retention sutures and feel that the skin edges when approximated with the subcuticular stitch have a better chance of healing by first intention

when there is no avenue of entry along the through and through type of retention suture.

I have never hesitated to do trachelorrhaphies and perineoplasties. (For purposes of my own cross index system I have used the word perineoplasty to denote an elective procedure.) I have never encountered any serious bleeding in these procedures. On only one occasion did a patient develop a hematoma. It was not necessary to surgically intervene in this case. In the repair of a cystocele or a cystourethrocele much more bleeding is encountered. One should be very careful in the selection of these cases and experience is the only teacher. If there is ever a doubt in my mind, these operative procedures are deferred three or four days.

No especial care is given to the operative field following the patient's return to her room. External douches of soap and water are used, and for comfort, the heat lamp. We make no attempt to prevent bowel movements, even when the repair involves the sphincter ani. In the repair of an old complete tear we prepare the patient before delivery with repeated enemas. When sutures are placed in the mucous membrane of the rectum, the use of mineral oil by mouth, or oil retention enemas, are definitely contra-indicated. There is no limitation of diet.

We believe in the routine administration of suitable oxytocics, hoping to keep the tone of the uterus at a high state to prevent the formation and later passage of blood clots. This not only tends to prevent severe after pains but saves unnecessary strains on the operative field when such clots are passing. We allow our patients out of bed the day following to use the

bed pan and afterward encourage the patients to arise several times daily. They are permitted to take a shower after the third day. We also urge putting the patient on her abdomen several times daily during her convalescence. The baby is allowed to go to breast after twelve hours.

I have been doing these procedures since 1936 and cannot note any increase in morbidity in this type of patient. Fortunately, we have had no deaths and it has not been necessary to do a secondary repair on any patient. Subsequent examinations at six months have sometimes led me to believe that I was not enthusiastic enough in my repair.

It has not been so long since obstetricians adopted episiotomy as almost a routine, especially when delivering the nulliparous patient. Its success has been well proved and in a large group of patients, where a comparison can be made between those having episiotomy and those not having this operation, impartial gynecologists note the much better condition of those patients in the former group.

Thus the obstetrician, while robbing the gynecologist of certain chores which he has in the past been accustomed to performing, is contributing to the economic convenience of the patient having these things done so that she may doubly accomplish the convalescence from her accouchement as well as her genital repair. It is difficult to understand why this procedure is not gaining popularity but like many accepted maneuvers of today it is, no doubt, destined to have a cyclic period of popularity before being accepted as a routine procedure with all obstetricians.

# Diagnosis and Treatment of Pigmented Moles and Melanomas

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Pigmented nevi and malignant melanomas are produced by benign and malignant neoplasia<sup>1</sup> respectively of melanocytes normally located at the junction of the epidermis and dermis of the body surface<sup>2</sup> and the epithelium and tunica propria of the adjacent mucocutaneous junctions and mucosae<sup>3</sup>. Pigmented nevi are very common, but melanoma is a rare disease. Its rarity is fortunate for the patients, but unfortunate for the physician, because he observes the disorder infrequently and his threshold of suspicion is so high that the patient is usually not given the benefit of early diagnosis and treatment. Since melanocytes originate in the neural crest, both pigmented nevi and melanomas present characteristics of nervous tumors, which differ greatly from benign and malignant tumors of epidermal cells, namely-seborrheic keratoses<sup>4</sup> and carcinoma.

## PIGMENTED NEVI

Most persons possess pigmented nevi, a majority of which appear early in life. Brown<sup>5</sup> and Michel<sup>6</sup> stated that they are almost never present at birth, although Kissmeyer<sup>7</sup> found that 35 per cent of newborn infants had macular nevi. Brown<sup>5</sup> stated that they rarely appear in the first year, occasionally in the second year, most commonly in the third year and later, so that most children possess them by the age of eight years. Michel<sup>6</sup> found ten nevi per adult, Pack<sup>8</sup> found 18 to 20, and Siemens<sup>9</sup> found an average of 30 macular nevi per person. In rare instances, the patient may be literally covered with hundreds of nevi, as reported by Zeissler and Becker<sup>10</sup>. Even though they are common on the skin, they are rare on the mucocutaneous junctions and mucosae. Nevi vary in appearance from macules, usually a few millimeters in diameter, which constitute the predominant type

up to four years of age (after ten years, half of them are elevated), varying up to several centimeters in unusual cases, through papular tumors to small and large elevated plaques, some of which cover large areas of the body (bathing trunk nevi). Early lesions are macular, while elevated ones, which may be covered with hair, have been present for a longer time. Nevi are asymptomatic, grow slowly with the patient and darken slightly, and are important for only two reasons: (1) cosmetic and (2) danger of development of malignant melanoma, especially at sites of continued irritation.

## BLUE NEVUS

A special type of nevus, discussed by Montgomery and Kahler<sup>11</sup>, which is less common than the ordinary congenital nevus, may appear at any period in life. Because the pigmented cells are in the deeper dermis, the scattering effect of the overlying tissue causes the brown pigment to appear blue. They may be macular or maculopapular, usually less than 1.0 cm. in diameter, and may occur on any part of the body surface. In rare instances, they may enlarge gradually to cover a more extensive area. They become malignant rarely, if ever.

## ACQUIRED NEVUS

During childhood or later in life, nevi may appear *de novo* in the form of flesh colored papules which become various shades of brown to blackish brown. They may appear in a large number at one time, as in the remarkable case reported by Ebert<sup>12</sup> or, more usually, singly. Pack<sup>13</sup> is of the opinion that acquired nevi are really congenital nevi that have remained clinically invisible until they started to enlarge.

## CLINICAL DIAGNOSIS

A brown lesion which has been present since childhood with no appreciable change except very slow growth and very slight darkening, is usually a pigmented nevus. In a study of 710 lesions diagnosed clinically as pigmented nevi by dermatologists and graduate students in Dermatology, the diagnosis was confirmed microscopically in

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the Dermatological Laboratory of the University of Chicago<sup>14</sup> in 80 per cent of instances. Of 649 specimens diagnosed microscopically as pigmented nevi, clinical diagnosis had been made in 87 per cent. Swerdlow<sup>15</sup> reported a series of 551 specimens at Michael Reese Hospital on which clinical diagnosis of pigmented nevus had been made by practitioners in all branches of medicine. Microscopic diagnosis of pigmented nevus was made on 61 per cent. Of 454 specimens on which microscopic diagnosis was made of pigmented nevus, clinical diagnosis had been correct in 74 per cent.

#### MICROSCOPIC DIAGNOSIS

Nevi which have been present only a short time show benign neoplasia of melanocytes at the junction of the epidermis and dermis. Intraepidermal nests of cells differ from melanoma cells by their lack of malignant neoplasia, failure to be cast off at the surface, and lack of lymphocytic infiltrate. The cells always resemble melanocytes, are fusiform or oval, are more basophilic than palisade basal cells, and have no intercellular bridges, so that they lack the cohesiveness seen in epithelial tumors. The cells are arranged in variously sized groups, which appear first at the epidermo-dermal junction, later are located more deeply in the dermis in groups, cords and strands. Still deeper, cells are elongated, and at times resemble Wagner-Meissner corpuscles. Superficial cells are apt to be pigmented with melanin granules, but deeper cells usually contain little or no pigment. Some nevi are completely depigmented, in which case nevus cells are usually confined to the dermis. They may consist of only the deepest cells, in which case<sup>14</sup> they have been called schwannomas.

The cells of blue nevus are melanin-containing cells, fusiform and elongated, situated between the collagen fibers in the deeper dermis.

#### TREATMENT OF NEVI

The current style in the therapy of pigmented nevi<sup>14</sup> is to remove all lesions at sites of trauma and friction to forestall melanoma formation and those for which the patient desires cosmetic treatment. Nevi at sites of friction may be excised surgically and submitted to the laboratory for biopsy to eliminate the possibility of melanoma. Cosmetic treatment of nevi, most of which are elevated, consists of snipping off the superficial portion for biopsy to eliminate mela-

noma, and cautery of the base sufficiently to obtain a smooth, almost negligible scar. I believe this method to be eminently safe if it is limited to tumors which are clinically quiescent. Large nevi should be excised *in toto* or piecemeal, with skin grafting if necessary, as in the case of giant nevi.

If blue nevi are treated, they should be excised.

#### MELANOMA

Malignant melanoma<sup>1</sup> is a tumor which arises due to malignant neoplasia of melanocytes at the epidermo-dermal junction of the cutaneous surface, or at the junction of the epithelium and the tunica propria of the muco-cutaneous junctions and mucous membranes. The first clinical sign of melanoma is in the form of a dark brown maculo-papule on the skin, lentigo maligna, or melanoplakia, usually blackish, on the mucosa. Lentigo maligna slowly enlarges and, after a few months or years, it becomes elevated, oozes serum and/or bleeds easily and, eventually, an elevated tumor appears, which may be pigmented in a shade varying from brown to black, or may be non-pigmented and erythematous. After a period which probably varies with the degree of anaplasia and rapidity of growth of the original tumor, local lymphatic extension and/or metastasis to the regional lymph nodes takes place. From the lymph nodes the tumor cells spread eventually into the blood stream and can grow in any tissue of the body. After extensive metastasis, indol bodies can be demonstrated in the urine<sup>16</sup> by the Thormahlen reaction and, in rare instances, generalized tissue melanosis<sup>17</sup> may occur.

The same process of malignant neoplasia can and does occur in the epidermo-dermal junction of pigmented nevi. As a matter of fact, Unna<sup>18</sup> stated that pigmented melanoma always arises from pigmented moles, rarely from unpigmented soft nevi. Willis<sup>19</sup> stated that nearly all melanomas arise from nevi, and Ewing<sup>20</sup> said that moles are the chief source of melanoma. Other workers reported percentages varying down to Miescher's 25 per cent<sup>21</sup>, Williams and Martin's 20 per cent<sup>22</sup>, and Daland and Holmes' 18 per cent<sup>23</sup>. In our laboratory, nevus cells were found in sections of melanoma in about 23 per cent of instances. The only actual proof of origin in a nevus would be the finding of nevus cells in melanomas. In routine laboratory slides, which

contain a few adjacent sections, the percentage of melanomas in which nevus cells can be identified, is usually less than 25 per cent. The only accurate method for such determination would be serial sectioning of the entire tumor, which is not feasible. The melanoma often outgrows the nevus, so that relatively few nevus cells can be seen. However, if the body surface of an adult is estimated at 16,000 sq. cm.<sup>1</sup> and the ten to thirty pigmented nevi possessed by most adults have an estimated surface area of considerably less than 100 sq. cm. it is at once apparent that melanoma arises at the epidermo-dermal junction in a nevus relatively many times more frequently than in normal skin.

#### JUVENILE MELANOMA

Allen and Spitz<sup>24</sup> recently called attention to the relative benignity of prepubertal melanoma as compared to the post-pubertal variety, and called it "juvenile melanoma". Even so, fatal melanoma has been recorded in children at all ages from new-born infants to puberty.

#### DIAGNOSIS OF MELANOMA

The diagnosis of early melanoma is difficult, so difficult that biopsy must be performed in all instances. According to Traub<sup>25</sup>, such a procedure is not dangerous if appropriate therapeutic measures are taken as soon as the diagnosis of melanoma is made. A recent study by Swerdlow<sup>15</sup> from Michael Reese Hospital emphasizes the difficulty in clinical diagnosis. Of 57 specimens diagnosed melanoma clinically, only 16 (28%) were verified on biopsy. Of 27 melanomas diagnosed microscopically, only 59 per cent had been diagnosed clinically. At the University of Chicago Dermatological Laboratory, from Oct. 1, 1927 to Mar. 27, 1953, clinical and/or laboratory diagnosis of melanoma was made on 244 specimens. Of 169 specimens on which clinical diagnosis of melanoma had been made by dermatologists and graduate students of dermatology, the diagnosis was confirmed microscopically in 72 (43%). Of 151 specimens on which the microscopic diagnosis of melanoma was made, clinical diagnosis had been made in 72 (48%). Poor as this average is, that for non-pigmented melanoma is even worse. The disorder is practically never diagnosed clinically. It is usually mistaken for granuloma pyogenicum.

#### MICROSCOPIC EXAMINATION

In lentigo maligna<sup>26</sup> neoplastic cells differing from melanocytes in that the nucleus and cell body are larger, but showing few if any mitotic figures, are seen at the epidermo-dermal junction, whence they spread in two directions. In addition to more pronounced anaplasia, the distinguishing feature from nevus cells is penetration through the epidermis to be cast off with the stratum corneum. They share with nevus cells penetration into the dermis. Here, however, another distinguishing feature is evident, namely, lymphocytic infiltrate, usually quite pronounced. When the tumor stage is reached, the cells may be more anaplastic. The cells may be ovoid or fusiform and in pigmented tumors melanin granules are present, usually in dust-like particles, of the same size in a given cell. The epidermis is disrupted by the enlarging nests of melanoma cells. Melanin-containing histiocytes are seen in the dermis in varying numbers.

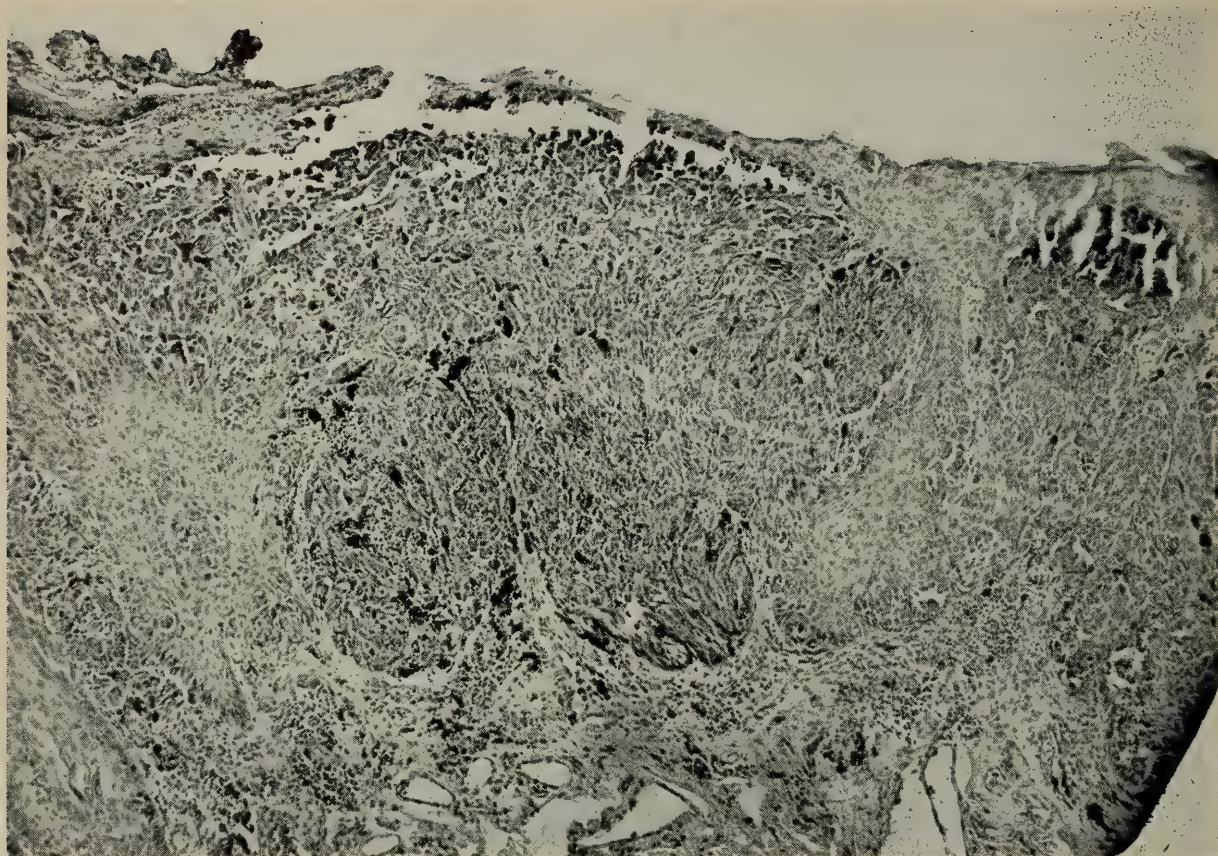
The microscopic appearance of early melanoma originating in a nevus differs only by the presence of nevus cells.

The following case represents early melanoma which originated in a congenital pigmented nevus, presented through the courtesy of Dr. J. W. Didcoct of the Carle Hospital Clinic, Urbana, Illinois.

Case 1.—A woman, aged 71, stated that she had had a mole 1.0 cm. in diameter on the upper back all her life. For two years the lesion had been extending in the form of a light brown macule. The original lesion had become elevated, and had bled during the past few days. The diameter of the entire plaque at time of observation was 3 cm. Microscopic examination showed a pigmented nevus with malignant melanoma in the central portion. The melanoma consisted of fusiform and oval cells which had thinned and practically eroded the overlying epithelium. (Figure 1) Moderate lymphocytic infiltrate was present and considerable melanin was present in histiocytes. Diagnosis was made of melanoma arising in a nevus. The lesion was excised widely and deeply on Jan. 12, 1952, and a split thickness graft was applied.

#### TREATMENT OF MELANOMA

It is essential that early diagnosis of melanoma be followed immediately by the best possible treatment. The only adequate therapy is destruction or removal. Because of the great tendency for the tumor to spread through the deep lym-



**Figure 1. Central portion of tumor showing malignant oval and fusiform cells. The dark areas are histiocytes**

**containing melanin. Lymphocytic infiltrate is visible. (H & E stain; x 80)**

phatics, considerable tissue must be removed, hence surgical procedures have supplanted all other forms of treatment.

Shortly after the *en bloc* removal of cancer of the breast with lymphatic channels and nodes was advocated independently by Willy Meyer and by Halstead in 1894<sup>27</sup>, Pringle<sup>28</sup>, applied this method in 1898 to the treatment of melanoma:

A girl, aged 17, had a melanoma on the left forearm which had appeared in normal skin and had been present for two years. A strip of tissue two inches in width was excised up to the axilla and the axillary lymph nodes, which contained metastatic tumor, were removed. She was presented thirty-eight years after operation<sup>29</sup>, with no history of recurrence and in excellent physical condition. Pringle's second patient, a man, aged thirty, had a melanoma, 3.0 by 4.0 cm. in size, of two years' duration, which had originated in a congenital mole on the left thigh. The tumor was removed along with a strip of tissue up to and including the lymph nodes as far as the bifurcation of the

common iliac artery. Metastatic tumor was found in the lower iliac but not in the upper iliac nodes. The patient was presented thirty years later<sup>29</sup>, with no history of recurrence, and in excellent physical condition.

The necessity for extensive tissue removal was demonstrated by Handley<sup>30</sup>, who found that progression was much wider in the lymphatics in the deep fascia over the muscles than in the superficial lymphatics in the skin. The method of surgical removal advocated by Pringle was recommended by Handley<sup>31</sup>. Others, Taylor and Nathanson<sup>32</sup> recommended primary wide and deep excision of the local area and, after a period of time, dissection of the regional lymph nodes. Raven<sup>33</sup> suggested that from ten to fourteen days be allowed to elapse between the excision of the primary growth and the block dissection of the regional lymph nodes. Pack, in discussing Raven's presentation, stated that amputation has some advantages over other operations in case the melanoma is located far out on an extremity. In regard to the delay between primary removal

and dissection of the regional lymph nodes, de Morgans admonition, delivered<sup>\*</sup> in 1872<sup>34</sup> should be considered. "Today, the glands may be free; tomorrow they may be affected. Today all the disease may be within range of an operation; tomorrow, disease may be distributed far beyond". For that reason, it seems to me that the sooner the lymph nodes are removed the better. Raven<sup>33</sup> also mentioned that only 50 per cent of lymph nodes involved in metastasis are palpably enlarged.

#### PROGNOSIS IN MELANOMA

The practising physician has two strikes against him when the patient comes for treatment. Clark and MacDonald<sup>35</sup> stated that in a Connecticut series of 349 patients, 48.8% of the males and 37.9% of the females had metastases when first seen. In a Texas series of 298 patients, 63.8% of the males and 60.6% of the females had metastases when first seen. The quiescent nature of the disorder has been somewhat compensated for by the current anti-cancer drives by the American Cancer Society and others which have called attention to the danger of asymptomatic brown spots on the skin. Hence, more patients are consulting physicians for advice. If biopsy is performed and early and adequate surgical measures are carried out if melanoma is diagnosed, the prognosis should improve. Pack<sup>8</sup> called attention to the improved prognosis as a result of more adequate surgical treatment. The fate of the patient with early melanoma is often in the hands of the physician. Adequate laboratory facilities for biopsy are available, use of which, followed by adequate surgical treatment, will result in an increasing percentage of cures. Even when early metastasis has already occurred, the situation is not hopeless, as shown by Pringle's report<sup>29</sup>, and by the recent statement of Capra and Ewing<sup>36</sup>: "Serious as is the outlook for the patient with a malignant melanoma, heroic resection will often salvage what appears to be the most hopeless case."

#### SUMMARY

1. Pigmented nevi may be removed (a) from sites of friction, and (b) treated for cosmetic reasons. All specimens should be biopsied to eliminate melanoma.

2. All pigmented lesions should be biopsied for the same reason.

3. Melanoma is treated by radical surgery.

4. Prognosis depends on early recognition of melanoma and institution of adequate surgical treatment.

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# Resistant Superficial Fungous Infections

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Chicago

Dermatophytes, the causative fungi of superficial fungus infections in man, thrive only saprophytically in the nonliving, horny structures of the skin which are the stratum corneum of the epidermis, hair, and nails. This predilection for keratin recently has been related to the low hydroxy-proline content of this material. The amino acid, hydroxy-proline, is found in all body proteins except keratin and exerts an inhibitory effect on the growth of dermatophytes.

Superficial fungi produce disease through two mechanisms: by direct disruption of invaded keratin structures as is particularly evident in hair and nail infections; and by evoking direct inflammatory or allergic reactions either locally in the underlying skin or in more distant structures in the form of id reactions.

In general those infections accompanied by sharp inflammatory reactions with much edema, vesiculation, or oozing are either self-limited or respond readily to any of a variety of common antimycotic measures combined with local supportive treatment. The relatively noninflammatory types of infections tend to be resistant and chronic. Some varieties of fungi whose natural host is man with particular frequency cause this

latter type of relatively noninflammatory infection. The important members of this group are *M. audouini*, the cause of common epidemic scalp ringworm in children; *Achorion schoenleini*, the cause of favus; and *Trichophyton rubrum*, the cause of the majority of dry, scaly, unusually chronic plantar, palmar, and nail fungous infections.

The *M. audouini* scalp hair infections are readily recognized by the bright green fluorescence of infected hairs under filtered ultraviolet light. The infected hairs are dull and break off readily while the surrounding scalp presents a slightly inflamed, scaly surface. The fungi invade the hairs half-way down into the portions buried within the follicles, which makes it difficult for antifungal preparations to reach all organisms. At puberty this type of infection often clears spontaneously probably by action of antifungal fatty acids produced physiologically at that time in larger amounts with the onset of increased sebaceous gland activity. *M. audouini* is especially sensitive to the action of such fatty acids. Conservative treatment for several months with manual epilation and vigorous application of potent fungicides such as salicylanilide-fatty acid mixtures often will cure mild cases; but in many extensive cases, temporary X-ray epilation of the entire scalp is necessary.

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Favus presents an even more difficult problem because it persists past puberty and leads to atrophic scarring and permanent baldness. Clinically characteristic cup-like incrustations, called "scutula", develop on the infected skin surfaces which have a peculiar mousy odor. X-ray epilation together with vigorous prolonged local use of fungicides usually is necessary for cure. Nail infections by *Achorion schoenleini* are particularly resistant to treatment. Although Favus is rare in this country, there are a number of endemic foci especially in the south.

The recalcitrant *T. rubrum* infections have some peculiar, little understood individual and local susceptibility factors. Only one individual in a family may be infected and even he may show local limitation of infection for many years to one hand or a few nails even though there is ample opportunity for spread by contact. Palmar localization also tends to be more common for this infection than is the case with other dermatophytoses. For laboratory confirmation of the diagnosis fungus filaments can readily be demonstrated by microscopic examination of KOH cleared specimens of infected horny material and on Sabouraud culture, characteristic red pigment producing, white, cottony colonies grow readily.

Attention recently has been called by Dr.

Lewis to an association of extensive *T. rubrum* infections with internal disorders such as lymphoblastomas. I have also seen severe rubrum infections in individuals with hypothyroidism, Cushing's syndrome, or severe liver disease. Recently Dr. Rothman has pointed out that otherwise normal individuals with chronic rubrum infections often have abnormally flat glucose tolerance curves.

The recalcitrance of these infections, in view of the high in vitro sensitivity of the organisms to antimycotic agents, is surprising. Clinically the hyperkeratotic element accompanying these infections is an important obstacle to therapy. Control of the lesions may require combinations of strong keratolytic or penetrating agents, such as salicylic acid on the skin or concentrated lithium bromide solutions on nails, as well as fungicides. Cure, especially in nail involvement, is practically impossible except on rare occasions by extremely persistent vigorous measures. Lesions on skin other than on palms and soles however, respond readily to ordinary antimycotic measures.

It is clear that there is need of further research on this admittedly almost intractable infection.

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## THE MAN FOR THE JOB

The unmeasurable factors that cause stress and fatigue in industry, such as emotional stimuli, boredom, social adjustment, etc., are certainly more numerous than those which can be measured. In spite of our ignorance of the quantitative importance of these imponderables, certain physical factors which lead to fatigue can be reduced. First, the environmental conditions can be improved to the best

possible level. Second, machines and tools can be designed for maximum efficiency with minimum physiological stress. Third, the workers can be chosen on the basis of their physiological fitness for the given job and the work can be organized to produce minimal fatigue. The accomplishment of these objectives requires the collaboration of the physiologist, the engineer, management, and labor. *Lucien Brouha, M.D., Fatigue — Measurement and Reduction. Indust. Med., Dec. 1953.*

# The Effect of Selenium on the Understanding and Management of Seborrhea

William N. Slinger, M.D.  
Rockford

Selenium is an interesting element. It is essential in the operation of an electric eye, it causes "blind staggers" in animals, it produces severe local and systemic poisoning in industry—and for some reason, it clears up dandruff.

My introduction to selenium for the treatment of skin disease occurred in the summer of 1948. As a resident in dermatology at Cincinnati General Hospital, I was asked to try an orange-colored, foul-smelling mixture on a group of patients with scalp disease. The mixture was selenium sulfide suspended in a detergent.

Selenium, as you know, is near sulfur on the periodic table and has some similar properties. The rather weak reason suggested for its use was the fact that sulfur has enjoyed much use in the treatment of skin ailments. If sulfur worked, why not selenium?

My enthusiasm for the project was slight for two reasons: Medicaments, including sulfur, had been put up in a shampoo form thousands of times for many, many years without any notable results; secondly, selenium is a definitely toxic element.

Because of the known toxicity of selenium, considerable caution was observed in the treatment of the first patients. We knew of "blind staggers" developing in animals following the ingestion of vegetation high in selenium content and we were aware of the manifestations of selenium poisoning in industry, but we did not know the degree of absorption of this element through intact or abraded skin.

Fortunately, selenium is eliminated primarily by the kidneys, and by collecting 24-hour specimens we were able to measure excretion levels. No significant increases occur following the application of selenium in a soap or detergent;

therefore, it was possible to use such a product for the treatment of scalp disease. The only one available as yet has been put out by Abbott and is called Selsun.

The selenium-shampoo mixture was first tried in ringworm of the scalp. The results were negative. Then a few cases of severe dandruff were shampooed with the preparation and good results were immediately reported by the patients. But it wasn't until I had treated some 30 or 40 persons with severe dandruff and some with fairly severe seborrheic dermatitis that I began to believe the substance would really work. In a great majority of cases, the itching and flaking would disappear after one or two shampoos.

The study was completed and we reported the results in 1951. Ordinary dandruff was found to be controlled in most cases but the shampoo became less effective as the skin involvement became more extensive and severe. The shampoo is not a cure, for even the mild cases of dandruff recurred if the shampoo was not used for three or four weeks. The preparation thus offers its greatest effectiveness in the least severe cases of dermatitis of the scalp.

While working with the selenium shampoo, the problem of toxicity was constantly in mind. However, the shampoo has been ingested in small quantities without observed toxicity. In fact, as much as a full bottle has been consumed without apparent ill effects. There have been numerous local reactions from the use of the shampoo preparation; however, most of these cases have been caused by the detergent. I know of only four cases of actual sensitization to the selenium per se; i. e., instances where the patient became sensitive to the selenium and this state of sensitivity was proved by patch tests.

Inasmuch as the selenium shampoo worked in a high percentage of cases, the next logical question was — will selenium in an ointment

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Presented before the Section on Dermatology, 113th Annual Meeting, Illinois State Medical Society, Chicago, May 20, 1953.

form clear up the more severe involvement where the rash extends onto the skin of the face and body. The final answer is not as yet available but I can state that the results of the clinical studies thus far completed are not nearly as impressive as those obtained with the shampoo.

Some individual patients treated with the selenium ointment have shown rapid improvement and complete control of a previously stubborn eruption. Many others are made worse. Furthermore, although we found no significant elevation of urinary selenium in the use of the shampoo, recent investigations do show a considerably greater rise in urinary excretion when selenium is applied to large areas of the body as an ointment. No toxicity has been observed in these cases, but the magnitude of urinary levels would discourage indifferent use of this type of application.

Very soon after we first began to use selenium prepared in a shampoo, we noted that the oiliness of the skin increased, and in some persons this increase was marked. How and why the increased oiliness was brought about was unknown. In some patients with dry, thin hair this was a welcome development, but in other patients the abundance of oil was wholly undesired and at times as disconcerting as the dandruff. To investigate the reason for the oiliness seemed to be the next logical step.

It is known that small amounts of selenium will decrease the drying properties of certain drying oils such as linseed, oiticica, and tung. This property may play an important role, but it was not thought to explain the enormous quantity of oil exhibited by some patients.

Was the increased oiliness responsible for clearing up the dandruff? Was there a "washing effect" by stimulated sebaceous secretion? Has the sebum of the diseased scalp produced the signs of skin irritation because of altered composition? Did selenium change the composition of the sebum or skin oil? These and many other questions arose and were left begging for answers because of the lack of understanding of the disease process and the paucity of basic facts concerning the physiology and chemistry of the sebaceous mechanism.

We know sebaceous activity is increased in certain nervous disorders. Increased excretion of skin lipids have been repeatedly demonstrated in Parkinsonism. Sebaceous activity is certainly

under some hormonal control, for administration of androgens stimulates sebaceous secretion. Castration leads to a marked fall in sebum secretion. Even normal values show a considerable variation in skin fat on different portions of the body as well as individual variation in a given area as influenced by temperature, humidity, general health, age, and nutrition.

However, we have never known a simple chemical administered systemically or locally to cause a frank increase in the oil or fat excreted on the skin. Selenium or  $\text{ses}_2$  does this — at least it appears to do so clinically.

Our recent investigations, therefore, have been to attempt to accurately and quantitatively record the changes in sebaceous secretion under selenium stimulation (if I may use this term). To do this a good method of collecting oil samples from the skin and accurately determining the weight of those samples was needed. It was my good fortune to find association with Dr. K. K. Jones and Malcom Spencer who have recently done pioneer work in estimating the rate of secretion of sebum from the normal skin.

To carry out accurate measurement of small quantities of fat from the skin or from the scalp, a fast sensitive method is of primary importance. To directly weigh each specimen of fat would be too tedious and inaccurate. We have therefore used the method devised and developed by Dr. Jones. The idea behind this method is simple and thereby more ingenious.

We all know that oil or fat spreads on water to form a very thin film of wide extent. It has been found that fatty acids spread to a film of one molecule in thickness. Therefore, by simply measuring the area of a spread you have all the necessary dimensions for calculating, with extreme accuracy, the weight of the fat. Establishing a factor for each sample by spreading a known weight would allow the adaptation of this method to any fat sample.

From the determinations thus far made we have consistently seen a marked elevation of the total skin fat occur about the third or fourth day after the use of the selenium shampoo. Dr. Jones has devised a reliable method of analysing each sample for the percentage composition of fatty acids, free and combined, the triglycerides, and the waxes. Although it is

too early to make definite conclusions, it appears that the composition of the fat on the diseased skin is quite different than on the normal skin. It also appears that the composition of the skin fat changes after skin contact with selenium.

Whether the selenium corrects an abnormal skin fat condition which is responsible both for the dermatitis and the changes in the skin fat is not yet proved. But we feel that the study of selenium and its interesting action on total fat excretion and its apparent ability to change the composition of skin fat may eventually give us some insight on the problem of seborrheic skin diseases. Selenium may be the key to open the way to better understanding of the basic physiology of sebaceous secretion.

DISCUSSION

Dr. Hilliard M. Shair, Quincy: I want to thank Dr. Spencer for his invitation to appear on this program and for the opportunity to study and to discuss Dr. Slinger's fine paper. The entire dermatologic profession has good reason to thank Dr. Slinger for his excellent work which has made possible our present use of selenium sulfide suspension. It is a real advance in management and most of us have adopted this preparation as routine treatment for dandruff and the milder forms of seborrheic dermatitis of the scalp.

Certainly the experimental work that Dr. Slinger has outlined in today's paper will increase our understanding of seborrhea. The effect of selenium sulfide suspension on the excretion of lipoids and the change in the composition and the surface tension of these liquids due to selenium sulfide is an important study and the results of the preliminary report in today's paper will be followed with interest by all dermatologists.

However, there is doubt in my mind whether these effects both clinically and experimentally in seborrhea are due to the selenium portion of the selenium sulfide suspension. Throughout today's paper, Dr. Slinger has spoken as if it is definite that the selenium portion of the compound is responsible for the activity of the medication. I think this is probably not right. According to the chemistry textbooks which I have consulted, selenium itself is a weaker oxidizing and reducing agent

than sulfur. I doubt whether a selenium compound without sulfur would show more activity than a sulfur compound. The selenium sulfide suspension is a fusion compound between selenium and sulfur of unknown composition. We are familiar in dermatology with three polysulfides. These are sulfuretted potash, sulfuretted calcium which is Vlemminck's solution and the quaternary ammonium sulfuret which is intraderm sulfur. Though the exact composition of selenium sulfide is unknown we can perhaps consider it another polysulfide. It may also possibly be an "activated" sulfur where selenium replaces one or more of the sulfur atoms in the ordinary  $S_8$  sulfur molecule ring.

Though selenium is a weaker chemical agent than sulfur, it somehow tremendously increases the activity of the latter element. This was first noted in the photoelectric cell where the addition of Selenium tremendously increased the photosensitivity of the sulfur.

Without in any way disparaging the efficacy of selenium sulfide suspension, it is possible that selenium in some sort of a catalyst (intramolecular?) which increases the activity of sulfur. From this point of view, we might better study sulfur further rather than selenium to understand the chemical mechanism involved in seborrhea.

In using selenium sulfide suspension with various soaps and shampoos, it has been noted that there are some incompatibilities. Certain proprietary shampoos may cause a gelation of selenium sulfide in the hair that is difficult to remove. This information I have received from the Research Division of Abbott Laboratories. They suggest the use of a plain bland soap for shampooing and have furnished me a list of shampoos which are compatible and incompatible with their product, Selsun.<sup>®</sup>

COMPATIBLE

Data	Prell Radiant Shampoo
White Rain	Luster Creme Shampoo
Richard Hudnut	Breck Shampoo
Toni Creme Shampoo	Phisoderm
Drene Shampoo	Acidolate

Tersus

INCOMPATIBLE

Herbal	Conti Castile Shampoo
Arex	Halo Shampoo
Formula 20	Tintair (Home Hair Coloring)
Palmolive Shampoo	
Fitch Shampoo	

## CASE REPORTS



### Congenital Absence of the Gall Bladder

**Max M. Goldenberg, M.D., F.A.C.S.**  
**East St. Louis**

A review of the literature reveals that congenital absence of the gall bladder is a rare anomaly. Although early case reports can be traced to a study by Courvoisier in 1890, little more than 75 cases have been reported to date, which were proven adequately enough for study.

A survey of cases discovered by autopsy shows that the incidence is approximately the same in both sexes. Among the cases discovered on the operating table there are two to three times as many females as there are males. This compares with the relative difference found in the incidence of other gall bladder and biliary tract conditions among the sexes.

I. W., female, age 36, gave a history of "gall bladder attacks" since age 7 or 8.

These attacks typically included epigastric distress, right upper quadrant pain and frequently were accompanied by nausea.

Five days prior to her first examination by the author she had an attack of nausea, right upper abdominal pain and slight diarrhea.

Her past history revealed a Caesarian op-

eration in 1942 and again in 1943. There is no mention in the report of these operations of examination of the gall bladder.

On physical examination she was seen to be a small woman of slight build.

The heart and lungs were within normal limits. B. P. 130/90.

The abdomen was slightly tender, just below the umbilicus in the midline. There was a midline lower abdominal scar. There was no tenderness in the right upper quadrant.

A telepaque study of the gall bladder was done and revealed a non-functioning gall bladder. Repeated two days later, the same result was obtained. A previous G. I. series had been done by others, which was reported as negative. A chest x-ray was likewise negative.

She was admitted to St. Mary's hospital in East St. Louis, where on July 22, 1953, operation was performed through an upper right rectus incision.

The liver appeared to be normal, and was not particularly enlarged.

A right and left hepatic duct were present. Upon emergence from the liver they joined into a common duct, which passed into the duodenum as usual. There was no vestige of a gall bladder and no indentation of the liver was present.

The duct was not noticeably larger than normal for a person of her size and build.

The duct was opened, about a centimeter distal to the bifurcation of the hepatic ducts and explored. A good sized probe passed easily into both hepatic ducts and into the duodenum.

There were a few fine adhesions around the liver, laterally to the chest wall.

The ducts were covered by a normal peritoneum and the walls of the common duct did not appear to be unusually thickened.

A T-tube was inserted with short horizontal arms and sutured into place.

A Penrose tube was inserted into the foramen of Winslow and both drains were brought out through a stab opening.

The appendix was removed in the usual manner without burial of the stump.

The abdominal wall was closed in layers and three stay sutures were used.

The patient made an uneventful recovery and was discharged from the hospital with a healed wound.

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## RELIEF OF VASOCONSTRICTION

The development of newer drugs which act by the inhibition of metabolic processes in special organ systems has given great impetus to specific drug therapy. The autonomic nervous system has been one of the targets of this type of investigation and development. Thus, newer drugs have been synthesized which act by blocking specific enzyme systems responsible for transmission of nervous impulses. Chemi-

cals which act on the sympathetic nervous system in this way lead to a reduction in blood pressure by reducing the outflow of vasoconstrictor impulses over this system. This offers a rather specific approach to the treatment of hypertension in which condition there is an excessive degree of vasoconstriction. *Ralph V. Ford, M.D., and John H. Moyer, M.D. Extract of Rauwolfia Serpentina in Hypertension. GP, Nov. 1953.*

# PATHOLOGY CONFERENCES

EDWIN F. HIRSCH, DEPARTMENT EDITOR



## CASE NO. 64277

Edited by E. L. Cheatle, M.D.

Wesley Memorial Hospital

*Clinical History:*—This 38 year old white female housewife entered the hospital with the complaint of vaginal bleeding of five months duration.

*Present Illness:* The patient stated that her last regular menstrual period was 2 years before hospital admission. There were no menopausal symptoms and she felt perfectly well until 6 months before admission when she had irregular vaginal spotting for a few days. Three months later there was an episode of moderate vaginal bleeding which lasted 8 to 9 days. Similar bleeding occurred 2 months before admission. The menstrual history revealed that menarche occurred at 12 years of age. The periods had been regular every 28 days with the flow lasting 4 to 5 days and of moderate amount. There had been no previous history of irregular menstrual periods or intermenstrual bleeding.

*Past History:* Five years before admission the patient had a left ovarian cyst removed at another hospital. At that time the left uterine tube and the appendix were also removed. The patient had had 4 normal pregnancies and 4 normal deliveries with no abortions.

*Physical Examination:* The temperature was 98.6 degrees F. orally, respiration 18, pulse 82 per minute and blood pressure 140/100 mm. Hg.

The patient was a well developed, obese white female who did not appear ill. The examination of the head and neck was not unusual. The chest was clear and there was no cardiac enlargement to percussion. The heart rate was regular and no murmurs were heard. Examination of the breasts revealed no masses or tenderness. The abdomen was soft and not tender. No organs or masses were palpated. The external genitalia were normal. Pelvic examination revealed a firm cervix of normal size which was posterior in position. The uterus was of normal size, shape and position. The left adnexa were not palpable. In the right adnexa there was a firm, freely movable non-tender mass which was stated to be the size of an orange.

*Laboratory Examination:* The urine was normal. Hematologic examination revealed 13.3 grams of hemoglobin per 100 cc. There were 4,330,000 erythrocytes and 6,400 leukocytes per cu. mm. A differential count of 100 cells showed 59 percent neutrophils, 37 percent lymphocytes and 4 percent monocytes. The Kahn test was negative.

On the second hospital day an operation was performed.

*Clinical Discussion:* Dr. Edward M. Door\* The history of this case is not unusual; a woman 38

\*Attending Physician, Department of Obstetrics and Gynecology, Chief of Obstetrical Service, Wesley Memorial Hospital.

years of age, obese, has had amenorrhea of two years duration and two or three episodes of bleeding. Five years ago this patient had an ovarian cyst removed. Ovarian tumors frequently are bilateral, especially cystadenomas and dermoid cysts. At operation, the other ovary may look normal, but may contain a small tumor which cannot be recognized grossly. This is particularly true of cystadenomas. So the pathologic diagnosis of this ovarian cyst might be helpful. Two years before admission the patient developed amenorrhea with no signs of menopause. The amenorrhea might be explained on a functional basis, and could be due to pituitary-thyroid dyscrasia or to ovarian dysfunction. The latter is most common in this age group. With pituitary dysfunction there is a disturbance in the follicle stimulating hormone mechanism, and possibly in the luteinizing hormone mechanism also. Small follicle cysts of the ovaries can cause amenorrhea, and so can ovaries in which there are functional disturbances. Psychic trauma may be another explanation of the amenorrhea. Pregnancy can be ruled out because of the time interval in the history.

The bleeding could be explained on a similar basis; dysfunction of pituitary or thyroid, or changes in the ovarian tissue could also cause vaginal bleeding. When pituitary function is deranged, excess follicle stimulating hormone exerts an ovarian influence and causes changes in the ovarian tissue and endometrium which results in vaginal bleeding. The same thing happens during the menopause, when a sudden episode of bleeding similar to a normal period may occur.

The vaginal examination of this patient helps us to rule out certain things. The cervix was essentially negative. There were no lesions such as cervical polyps to cause the bleeding. We could expect a different type of bleeding with that type of lesion. I think we can rule out lesions of the body of the uterus, that is, of the endometrium, because the uterus was small, of normal size and shape. There were no fibroids palpated, but the patient might still have a small fibroid. Carcinoma of the fundus or endometrium is common in this age group, but again we would expect a different kind of bleeding. An endometrial polyp can be ruled out as the patient

had no apparent estrogenic stimulation. We must assume the adnexal mass to be ovarian. It was solid and freely movable. Benign tumors do not usually cause vaginal bleeding. Indeed, few tumors do. A persistent corpus luteum might be associated with this kind of history, but the bleeding would be more profuse. Endometriosis with chocolate cyst formation might cause bleeding, but this does not fit with the pelvic findings. Ovarian carcinoma may produce bleeding and that is one of the things we must consider. Feminizing tumors, such as theca cell tumors and granulosa cell tumors must also be considered. Granulosa cell tumors are rare. About 50 percent are found during the childbearing age, 5 percent during puberty, and the rest during the menopause.

My first choice for the diagnosis is functional uterine bleeding, due either to pituitary-thyroid dysfunction or ovarian dysfunction; second, ovarian carcinoma; third, granulosa cell tumor, and fourth benign ovarian tumor.

*Dr. Thomas C. Laipply:* If functional uterine bleeding is your first choice, how do you explain the adnexal mass?

*Dr. Dorr:* Very frequently, along with functional bleeding the patient has a benign tumor which is not functional.

*Dr. Laipply:* Like a fibroma?

*Dr. Dorr:* Fibroma, cystadenoma or papillary adenoma. I would lean toward a solid ovarian tumor because of the description.

*Dr. J. Chandler Smith:* If the whole clinical picture in this case is on the basis of ovarian carcinoma of two years duration, shouldn't there be metastases by this time?

*Dr. Dorr:* Theoretically, yes, although some papillary tumors of the ovary can be present for a long time before they metastasize. A solid tumor might metastasize more readily than a papillary cystadenocarcinoma. Of course we have to assume that the mass was present two years ago. Maybe it wasn't there at that time. We do not know if the patient was examined two years ago.

*Dr. Emery G. Grimm:* Polycystic ovaries might be the cause of this patient's symptoms. Such patients may have functional bleeding or amenorrhea.

*Dr. Dorr:* Polycystic ovaries can produce amenorrhea and occasional episodes of bleeding.

Theca cell tumors rarely produce estrogen. Granulosa cell tumors produce estrogen, an excess of which causes amenorrhea. Bleeding occurring with a granulosa cell tumor is accounted for by degeneration within the tumor causing an estrogen withdrawal, which in turn causes bleeding. The cut sections of such tumors frequently show cystic cavities, the result of degeneration and hemorrhage.

*Dr. Laipply:* Dr. Grimm, what is your diagnosis?

*Dr. Grimm:* A polycystic ovary would seem most likely, although they are usually smaller.

*Dr. Dorr:* I ruled out that diagnosis on the basis of the physical examination. Such tumors are usually smaller.

*Dr. Laipply:* Is the age compatible?

*Dr. Dorr:* Yes. Usually polycystic ovaries are diagnosed earlier, but they can occur at this age.

*Dr. Arthur E. Mahle:* Were x-rays taken? Is it a good idea to take an x-ray of the pelvis each time a pelvic tumor is found?

*Dr. Dorr:* We don't take x-rays routinely in these cases, since dermoid cysts are about the only tumors that are distinguishable. Routine gastrointestinal x-rays are not of much help with most adnexal masses. However, if the mass is in the left adnexa a barium enema may be very helpful to exclude lesions of the sigmoid colon.

*Dr. Mark T. Goldstine:* The description does

not sound like a dermoid cyst. When a dermoid cyst is palpable it has weight. It is heavy, movable, and has the feel of putty. The tumor in this case is much larger than most arrhenoblastoma or adrenal tumors in the ovary, both of which can cause amenorrhea. However, with these tumors the patient rarely bleeds again; in fact patients with arrhenoblastomas bleed only after the tumor is removed. The obesity of this patient fits with hypothyroidism. I think ovarian pregnancy or a very old tubal pregnancy should be considered, although the history favors granulosa cell tumor.

*Dr. Smith:* In most cases of granulosa cell tumor, is there not more evidence of estrogenic stimulation?

*Dr. Dorr:* Usually not. However, one of the few things such patients do complain of, is enlargement of the breasts.

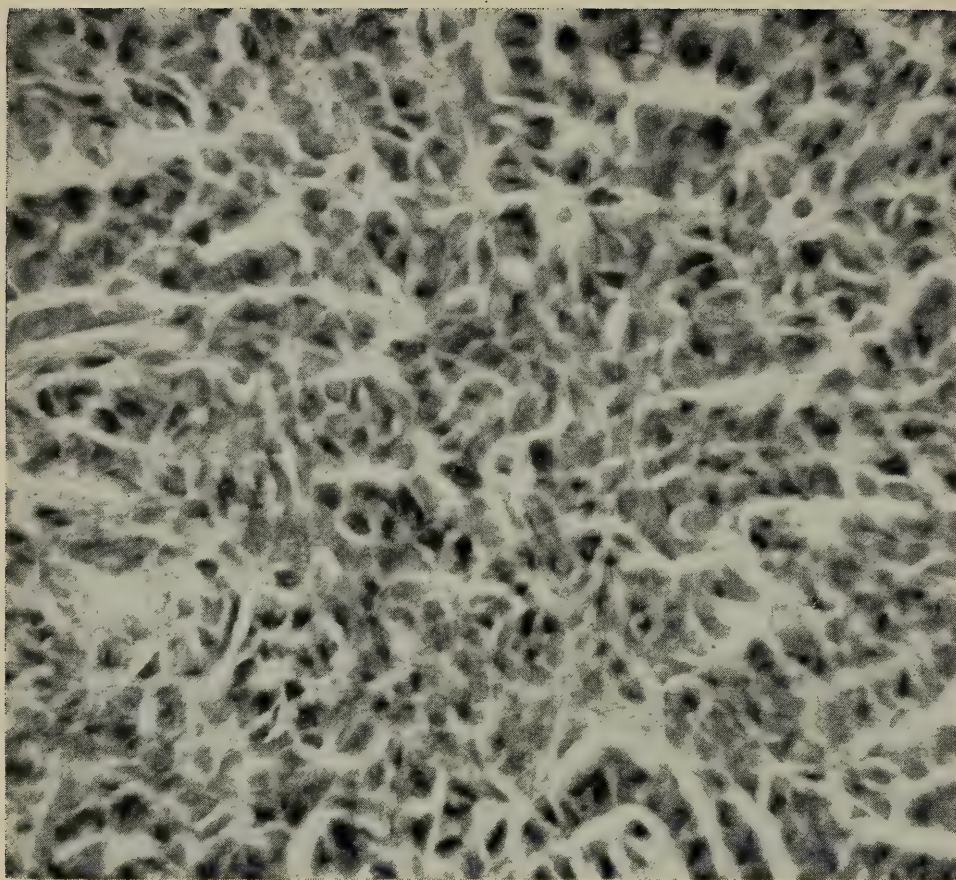
*Dr. Goldstine:* This patient is old for a granulosa cell tumor to cause amenorrhea and then to result in vaginal bleeding again. Usually those that start to menstruate again after amenorrhea are in the 20's.

*Dr. Dorr:* The bleeding could be explained by degeneration and necrosis within the granulosa cell tumor. With the development of a solid tumor mass the estrogen levels are high; with necrosis, withdrawal bleeding occurs.

*Dr. Laipply:* Dr. Dorr, do you think it is better to combine two diagnoses instead of choosing one?



Figure 1. Granulosa cell tumor of ovary. Polyp of endometrium.



**Figure 2. Photomicrograph showing trabecular pattern of granulosa cell tumor.**

*Dr. Dorr:* I believe one diagnosis should be used in most instances. In gynecologic problems frequently two things are going on at the same time. I still think functional uterine bleeding and benign ovarian tumor is my first choice as a diagnosis.

*Clinical Diagnosis.*—Solid tumor of right ovary.

#### *DR. DORR'S DIAGNOSIS*

1. Functional uterine bleeding and benign ovarian tumor.
2. Carcinoma of ovary.
3. Granulosa cell tumor of ovary.

#### *ANATOMICAL DIAGNOSIS*

Granulosa cell tumor of ovary.

Polyp of endometrium.

Acute and chronic cervicitis.

Uterine tube — no pathological diagnosis.

*Pathological Discussion.*—*Dr. Laipply:* This was a typical granulosa cell tumor of the ovary which weighed 35 grams and measured 6.5 cm. in diameter. The uterus was of average size and the early proliferative endometrium showed no estrogenic effect.

Granulosa cell tumors are solid and yellow or orange in color. As Dr. Dorr mentioned, hem-

orrhage and degeneration are common and in this case the degeneration could have produced withdrawal symptoms. (Figure 1)

Microscopically the tumor has the classical picture of a granulosa cell tumor. (Figure 2) Such tumors are so called because the microscopic appearance simulates that of the granulosa cells of follicles. The tumor is made up of angular spindle-shaped cells which tend to line up in parallel cords. A trabecular arrangement is common. Follicular arrangement of cells is sometimes seen. The uniformity of cells justifies classifying the tumor in this case as benign.

Granulosa cell tumors may produce signs and symptoms due to increased estrogenic stimulation.<sup>1</sup> The endocrine effects of granulosa cell tumors depend upon the age group in which the tumor occurs. Abnormal uterine bleeding is present in half of the cases. Before puberty precocious development of secondary sex characteristics may appear. During the reproductive period in one half of the cases, there are irregular periods of amenorrhea and prolonged bleeding. During the menopausal period there is abnormal menstruation in 54% of cases. In the post

menopausal patient bleeding occurs in 62 per cent of the cases. Any abdominal enlargement is probably due to ascites.

These tumors are usually benign as judged by absence of metastases, recurrence and invasion. Some of the tumors recur, probably because of incomplete excision. There are metastases in less than 2 per cent and the tumors are benign in 65 to 97 per cent of cases. Thus the prognosis is usually good.<sup>2,3</sup>

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## SILo DEATHS

The first American silo was built by Dr. Manley Miles in 1875. At least as early as 1900 it was well established by Babcock and Russell, in the Annual Report of the Wisconsin Agricultural Experimental Station, that the products of fermentation within the silo during and shortly after filling include high volumes of carbon dioxide. Since that time scores of other reports from sources close to agriculture and dairying have warned that the silo at this season of its filling is a veritable lethal chamber. In the shredded cornstalk, with its fodder and corn, the carbohydrate content undergoes rapid atmospheric oxidation. The oxygen in any confined space is consumed speedily. Bacterial action provides fermentation. Carbon dioxide is evolved. It is not unusual for the percentage of carbon dioxide to reach 38, when the usual atmospheric content of carbon dioxide ap-

proximates 0.2 per cent. By best definition, carbon dioxide is not a poison. The victim rapidly succumbs to oxygen deficiency. The normal oxygen content of the air is depleted in the chemical reaction but the situation is compounded by the production of carbon dioxide. The victims are asphyxiated quickly and insidiously. Opportunities for prevention are numerous and some are simple. One of the simple ones involves the architecture of the silo itself. If workers are to be required to pack down insilage, every silo should be so constructed as to possess multiple hatchways or doors that provide openness up to successive levels at which the work is performed. Better still, and perhaps in addition to the foregoing, a blower with suitable piping should operate at all times when workers are present inside the silo so that respirable air may be supplied. *Editorial, Autumn Slaughter. Indust. Med., Dec. 1953.*

## EDITORIALS



### IMPROVING ON OSLER

Bedside teaching was introduced by Osler early in the 20th century. He brought third-year students into the wards where they received firsthand information on disease. Many modern faculties believe that bedside teaching ought to be started earlier and some schools now provide a weekly or monthly clinic for freshmen. For the past four years the course, "Introduction to Medicine," has been given to beginning students at the University of Buffalo School of Medicine. The student body is divided into groups of five that meet once a week under the guidance of a preceptor. These teachers are selected carefully and do not use a prescribed outline or prearranged lecture. The following report is typical of what takes place when the group is together:

"We went on to discuss the flow of cerebrospinal fluid, how its pressure might be measured, and how much might be removed at one time. . . . how soon it would be re-formed, and what information might be gained from such a procedure as this. Each of the five students then made a guess as to how deep the needle would have to be introduced in our patient before fluid would be obtained. These varied from one-half inch to the full length of the needle. There was a great deal of satisfaction for all of us when the young intern (just barely out

of medical school himself) stepped up to the bedside and produced the clear flow of cerebrospinal fluid by placing a needle into this patient's back between two spines, presumably along a course dictated by the laborious dissections of the Grays, Morrises, Cunninghams, and their predecessors."

These young men and women are unspoiled by previous protocol and preconceived methods of history taking. They ask questions about the patient's background, environment, and occupation and appear more sympathetic with his nonmedical needs, comforts, and cares. In this respect, the younger student does not have the cold, brusque, businesslike approach to diagnosis and treatment observed so commonly in seniors. Educators who advocate this method of teaching hope that the freshman will retain this desirable quality; and that he will not reach the stage of looking upon man simply as a series of sagittal sections, biochemical reactions, case histories, or cardiacs. To date there is no evidence that the plan is weaning medical students away from the basic sciences or giving them that "little knowledge" that is reputed to be so dangerous. On the contrary, there is evidence that these young people are mastering fundamental skills and basic principles.

Many medical schools are getting away from didactic teaching. Most of us oldtimers will

recall sitting all morning listening to textbook lectures on medicine, surgery, obstetrics, and ophthalmology. In the afternoon, an hour of urology was crowded in followed by lectures on gynecology, dermatology, and medical economics.

At Northwestern University Medical School, the junior class is divided into small groups, assigned to various hospitals, where lectures are given in conjunction with bedside teaching. These students see their alma mater so seldom during their last two years that they hardly know what the place looks like.

Several medical schools throughout the country are putting the family back into medical education. They are sending their students out to make house calls under the supervision of a clinic physician. This encourages the student to consider the entire individual because it makes him more cognizant of the effects on health and disease of environment and family situations. This is nothing new to most general practitioners in Illinois who appreciate the value of knowing the patient as a total person.

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## THE REORGANIZATION MEETING OF 1850

The first Illinois State Medical Society organization meeting was held in Springfield, in June, 1840. The Society has in its possession a membership certificate issued to a member in LaSalle County in 1841. Although transactions of the first meeting are still in existence, there remains but little evidence of subsequent meetings.

The Society met in 1847, at which time Dr. John Todd was elected president and David Prince secretary. At this meeting delegates were selected to attend the National Medical Convention. References of some activities still exist, however, and references appeared in various publications of the fee bill adopted by The Medical Society of Illinois.

The story of the organization of the Society again in 1850, is well known to many of our readers. However, there are many interesting facts relative to the motives and activities of Illinois physicians of this period, in reference to this reorganization meeting, that are not so well known.

In 1893, the Illinois State Medical Society selected a special committee on the history of

the Illinois State Medical Society, of which Dr. William O. Ensign of Rutland was chairman. The committee was asked to submit a report at the next annual meeting, but it was not prepared in time for that session. However, Doctor Ensign did give a report at the annual meeting in 1895, which was published in the transactions of that annual meeting.

Doctor Ensign stated that in 1849, there were four district societies which participated jointly in the reorganization plans. The first of these, The Rock River Valley Medical Society, organized at Rockford February 17, 1846. Its field was stated as "Northern Illinois and the Southern portion of the Wisconsin Territory".

The Aesculapian Society of the Wabash Valley was also organized at Lawrenceville in 1846. Its members were principally physicians located along or near the Wabash River Valley, in Illinois and Indiana.

The Peoria City Medical Society, organized in Peoria, April 19, 1848, was composed of members from the counties of Peoria, Fulton, Stark, Tazewell, Woodford, and other nearby counties.

In 1847 "The Medical Societies of LaSalle and Adjoining Counties" was organized, but it was active for only a short time. On January 1, 1849, The Ottawa Medico-Chirurgical Association was formed, to replace the former organization. At its meeting in June of that year, by a formal vote a circular was sent to the "three other societies, and others in the state" in which they were urged to join together in the efforts to get an active state medical society in Illinois.

At about the same time the Aesculapian Society, by formal action at a regular meeting, decided to ask for the organization of an active state medical society. They too were anxious to procure the assistance of the other organized medical societies of the state to join with them in this venture. Consequently both of these societies, the Ottawa Medico-Chirurgical and Aesculapian Society, thought they actually initiated this proposal. With a distance of some 245 miles separating these cities of Ottawa and Lawrenceville, it seems quite probable that the idea was discussed in both societies at about the same time. The Northwestern Medical and Surgical Journal, in its September, 1849 issue,

commented on this proposal and gave credit to the Ottawa Society for initiating the plan.

Letters were sent to medical societies, to Rush Medical College, and to many individual Illinois physicians telling of the proposed plans to hold a meeting in Springfield on the second Tuesday in June, 1850, to organize a permanent Illinois State Medical Society.

According to Doctor Ensign, there still existed in 1895, the original responses of quite a number of prominent Illinois physicians. Among these he stated were Drs. A. G. Henry, Springfield, Nicholas Hard, Aurora, Dexter G. Clark and A. M. Catlin, Rockford, E. M. Colburn, Bloomington, J. J. Lescher, Mt. Carmel, R. S. Moloney, Belvidere, W. W. Welch, Inlet Grove, C. H. Ray, Mackinaw, Daniel Stahl, Quincy, L. D. Boone, Chicago, Joseph Blount, Rockport, and Elijah C. Banks of Lawrenceville. All of them expressed a firm belief in the desirability of having a statewide medical organization and gave assurance of their desire to cooperate in the project.

The official call was made by the president and secretary of the Ottawa Medico-Chirurgical Association under date of December 18, 1849, for a meeting to be held in Springfield at the State Capitol Building, on the first Tuesday of June, 1850. This was published in the Northwestern Medical and Surgical Journal, and all existing medical societies in Illinois, as well as physicians individually endeavored to be present on that occasion.

Following its publication, an editorial appeared in the Northwestern Journal, approving the proposed organization of a permanent State Medical Society, and signed by the initial "E" and it was written by John Evans. We are fortunate in still having this editorial available, as herein presented:

"We heartily approve of the convention of the physicians of this state which is called to meet on the first Tuesday in June, next, at Springfield, and hope our professional friends throughout the State will promptly engage in the enterprise and make arrangements to give the meeting a full attendance. It will come at a season of the year when the country is generally healthy, and in this respect the time will be opportune, unless we should again be visited with the cholera.

"The roads are generally good and the weather

pleasant at that season, so that few obstacles will be in the way and we may hope to see a large delegation of physicians from all parts of the State. Mutual acquaintance, the promotion of harmony and concert of action, fostering friendly feeling and good fellowship, mutual improvement by interchange of sentiment and organization for the promotion of the common interests of the profession, may be objects of little importance to some, but we are sure that a large portion of the intelligent members of the profession of Illinois love their calling and its high benevolent aims too well to lightly regard or neglect them. Besides it is the opinion of the profession of the United States as expressed through the National Medical Association that such organizations should be formed".

A later editorial in this journal, written by Doctor Meek, again urged upon the profession of the state the importance of attendance and mentioned some of the benefits to accrue from a full representation.

The Rock River Medical Society, Rush Medical College, The Aesculapian Society of the Wabash Valley Association, the Ottawa Medico-Chirurgical Association, and several other societies named official delegates to attend this reorganization meeting in Springfield. The records show that actually there were 13 physicians present from outside the state capital and three or four from Springfield attended part of the organization sessions. There were 29 enrolled as delegates for the meeting, nearly half of whom were unable to be present.

Several travelled to Springfield in buggies, taking two or three days to make the trip, while others took stage coaches for the trip. In order that they might spend two days in Springfield, several had to be away from their work for a week or ten days. Doctors William B. Herrick and James V. Z. Blaney, from Rush Medical College, were active participants in this reorganization meeting, and Doctor Herrick was selected as the first permanent President of the reorganized Society.

In his excellent report, Doctor Ensign gave some interesting data relative to each of the physicians present at this convention, as well as a number of others who were unable to attend. All of these desired to become charter members of the reorganized Society.

Some interesting information was given in the Transactions of the Annual Meeting of 1895, relative to membership of a number of the component societies. The Chicago Medical Society boasted of having 761 members, and its own official journal, The Chicago Medical Recorder. The number of members of other societies, as reported were:

McLean	62	Peoria	35
LaSalle	58	Morgan	38
Adams	45	Winnebago	28
Aurora	33		

District Medical Societies, entitled to send delegates to the annual meetings were:

Southern Illinois Medical Association	200
Military Tract Medical Association	150
North Central Illinois Medical Association	112
Aesculapian Society	105
Capitol District Medical Society	62
Fox River Valley Society	60
Brainerd District Medical Society	57

The Transactions of the Illinois State Medical Society were published each year following the annual meeting from 1850 until 1899, when the Illinois Medical Journal was developed. Since 1899, the actions of the House of Delegates have been published in the Journal. Many interesting items are found in these transactions pertaining to medical care, medical legislation, and even to the early endeavors to improve the relations between the medical profession, their patients, and the public in general.

## GETTING A DOCTOR NIGHT OR DAY

Many County Medical Societies have set up an emergency call system which can be used in an emergency to get a physician in a hurry. Similar plans have been developed in many cities of Illinois and elsewhere. Robert R. Mustell, chairman of the Emergency Service Committee of the Chicago Medical Society in a recent report, stated that 2,185 calls were handled during 1953 through this system. In most cases a physician answered the call within a period of from 15 to 30 minutes.

The service maintains a list of physicians willing to make emergency calls day or night. These are arranged according to their locations, and it is relatively easy to call one of these physicians for emergencies in the area where the call originated. The Emergency Service Committee is

now considering a pocket phone service to speed up responses to these emergency calls. By means of a small radio receiver, the service can broadcast the number of the physician desired on a special wave length. When the call is picked up, the physician immediately calls the service for information and directions for making the call. Signs carrying the number of the call system have been placed in all drug stores, hospitals, hotels and apartment hotels so that more people will become aware of the service offered to them in an emergency.

Emergency call services arranged by city or county medical societies have proven to be a valuable service in case of emergencies where a physician is needed at once, and the family physician cannot be reached. It is hoped that similar services will be set up throughout the State of Illinois, and that they be widely publicized, as has been done in the Chicago Medical Society Emergency Service Plan.

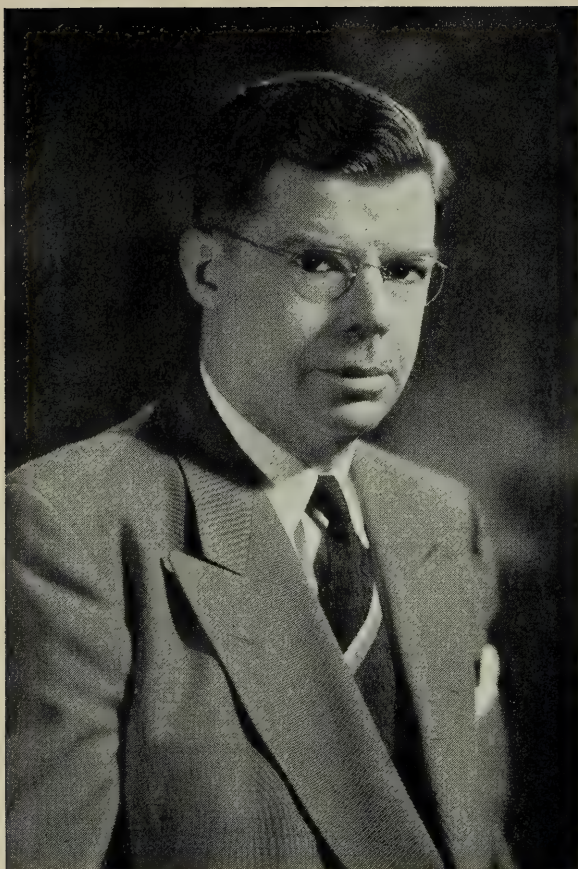
## NEW DEAN AT UNIVERSITY OF ILLINOIS COLLEGE OF MEDICINE

Dr. Granville A. Bennett, 52, was appointed dean of the University of Illinois College of Medicine by the Board of Trustees at its meeting here Tuesday afternoon.

Dr. Bennett presently serves as professor of pathology and head of the department at the University's College of Medicine, and pathologist-in-chief of the Research and Educational Hospitals.

He will assume the duties of the deanship sometime this spring, on a mutually convenient date to be determined later. He will replace Dr. Roger A. Harvey, who has served as acting dean since Jan. 1, 1953. Dr. Harvey will return full-time to his position as professor of radiology and head of the department in the College of Medicine, and radiologist-in-chief of the Research and Educational Hospitals.

Dr. Bennett has been head of the Department of Pathology at the University of Illinois since 1944. In addition to his University appointment, he presently is chief editor of the scientific publication, "Archives of Pathology." He is consultant to the Armed Forces Institute of Pathology, and consultant in pathology to La-Rabida Jackson Park Sanitarium, Chicago. He is a member of the Council of the American



**Granville A. Bennett, M.D.**

Association of Pathologists and Bacteriologists, and a member of the Executive Committee of the Institute of Medical Education.

Prior to coming to Chicago in 1944, he was head of the Department of Pathology and Bacteriology at Tulane University. He taught at Harvard Medical School from 1927 to 1943, starting with the rank of instructor and attaining the rank of associate professor.

He holds the bachelor of science and doctor of medicine degrees from the State University of Iowa. Harvard University presented him with an honorary master of arts degree in 1942. He received his specialty training as a resident physician at Peter Bent Brigham Hospital, Boston, Mass.

Dr. Bennett's research interests have been concerned chiefly with structural and functional characteristics of bones and joints and with diseases of the skeletal system. He is the author of 67 scientific papers and one book, "Changes in the knee Joint at Various Ages with Particular Reference to the Nature and Development of Degenerative Joint Disease." He also has con-

tributed sections of textbooks in pathology and surgery.

The newly-appointed dean is a past president of the Chicago Pathological Society, the Illinois Society of Pathologists, the American Association of Medical Museums, and the New England Pathological Society. He is a former member of the Pathology Study Section of the National Institutes of Health.

Dr. Bennett is a fellow of the College of American Pathologists, having served as the organization's vice-president and a member of the Board of Governors. He holds membership in many other scientific groups, including the American Society for Experimental Pathology, the Society for Clinical Investigation, the Society for Experimental Biology and Medicine, and the American Society of Clinical Pathology.

A native of Hiawatha, Kan., he is married and has one daughter. They reside at 421 West Barry Ave.

## **CATASTROPHIC ACCIDENTS IN 1953\***

Catastrophes are considered as accidents killing five or more persons, and during the past year they took approximately 1800 lives in the United States. A major factor was the unusually heavy loss of life in tornadoes.

Thirteen tornadoes killed more than 450 persons, and four of these storms sweeping through thickly populated areas were responsible for most of these deaths. The first of these struck Waco, Texas on May 11, taking 114 lives. The second and largest was a series of twisters which swept through Michigan and Ohio on June 8, in which 142 persons were killed, mostly in the Flint, Michigan area. On June 9, a storm through Worcester County, Massachusetts, fatally injured 88 people. On December 5, a fourth storm passing through Vicksburg, Mississippi, left a death toll of 38.

During 1953, there were eight other disasters, which claimed more than 25 lives. Five of these were plane accidents, taking the lives of 193 people. An explosion and fire on an aircraft carrier was responsible for the loss of 37, and an explosion and fire in a Chicago electrical

\*Metropolitan Life Insurance Company, Information Service. 1-12-1954.

appliance factory took 35 lives. A nursing home was destroyed by fire in Largo, Florida, taking 33 lives. Fires and traffic accidents were responsible for loss of life in many of the other catastrophes in various parts of the nation.

According to the Metropolitan Information Service, catastrophes took a higher toll of lives in the United States during 1953 than in any year since 1947.

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## DO YOU WANT TO GO TO EUROPE?

The Eighth General Assembly of the World Medical Association will be held at Rome, Italy, September 26-October 2, 1954. The United States Committee, Inc. has several suggested tours and itineraries arranged in connection with this Eighth General Assembly, arranged by the Rounds Travel Service, Inc., 52 Vanderbilt Avenue, New York City. In addition to the main itinerary covering the dates of the Assembly, they have prepared a choice of eight pre-conven-

tion and post-convention itineraries covering all countries on the continent.

Carefully selected accommodations have been reserved in Rome with deluxe, first class and standard rates. The United States Committee, Inc., suggests that those desiring to go to Europe this year and those planning to attend the Eighth General Assembly contact the Rounds Travel Service now to assure the contemplated European plans. They would also appreciate having an early estimate of the number from the United States who will attend the General Assembly, in order that adequate reservations may be made for the social functions.

Dr. Louis H. Bauer, Secretary-Treasurer of the World Medical Association, would like to see a good representation at the Conference this year, and additional information may be procured by writing him in care of the World Medical Association, 345 East 46th Street, New York 17, New York.

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## TELL ME MORE

The doctor should develop an ability to tell his patients how they are going to feel under treatment. The pediatricians have long used this technique with the mothers. When Dr. Jones tells Mrs. Brown that in a few weeks Johnny will do thus and so, and Johnny does it, Dr. Jones is a great and wise man. There is no reason why we should not tell our patients how they are going to feel when we place them on a reducing diet. We know that, in many fat people, eating is one of the ways of reducing emotional tension and that when this tension is not relieved by eating, symptoms of anxiety and weakness will develop. The patient should know that we expect this, and that these symp-

toms are not the result of weakness of the body because of inadequate calories. Melancholy is one of the symptoms of infectious hepatitis. The patient should be warned of the development of the symptom as a part of the illness. It makes it easier to handle if the patient knows that the doctor understands his feelings. Patients with hyperthyroidism are always in a hurry to get their workup completed. This push is part of their illness. Patients on ACTH therapy will handle mild delirium better if the doctor recognizes the first signs and interprets their confusion to them as being doctor-made. *Eugene A. Stead, Jr., M.D., Treatment of Chronic and Undiagnosed Illnesses. GP, Nov. 1953.*

# MEDICAL ECONOMICS

The Medical Economics Committee. John R. Wolff, Chairman, Walter C. Bornemeier, Edward W. Cannady, Roland R. Cross, Jr., E. F. Dietrich, W. W. Fullerton, Edwin F. Hirsch, Frederic T. Jung, W. R. Malony, Caesar Portes, William Requarth, Frederick W. Slobe.



## Public Aid Medical Program

### Part II

**W. Robert Malony, M.D.**  
**Pittsfield**

In the June 1953, Illinois State Medical Journal, an editorial was written which consisted of the first part of this paper. At that time evidence was given to show that the Medical Advisory Committee to the Illinois Public Aid Commission was doing a necessary and vital part in regulating and helping the administration of that program. It was also pointed out that, at various times, information was published in the state medical journal relative to the Public Aid Program and the necessity for various regulations and restrictions which were imposed. It was mentioned that the Advisory Committee, in this way, was able to keep the program more or less under the direction of the physicians of the state as regards the medical portion thereof. Now recently we have the announcement that the Advisory Committee from the state level will issue periodically a bulletin to all participating physicians which will give more complete information in regard to this medical program.

On the other hand there are undoubtedly numbers of physicians who participate in the care of recipients of public aid in this state who are not satisfied with the administration of

the program. As an illustration, I can quote paragraph three of a letter which was written by one of the county medical societies to Governor Stratton regarding the medical care of the Public Aid patients, the letter being dated April 28, 1953.

At the present time the recipients of medical care under this program have had their medical care drastically reduced in the following manner:

- (a) The type and cost of drugs has been markedly reduced.
- (b) Regulations state that no orthopedic appliances of any sort may be procured for these individuals.
- (c) The hospitalization of a patient by his doctor must be approved by the local public aid office and local Medical Advisory Committee before a patient is hospitalized except in case of emergency.
- (d) The number of hospital and home visits a physician may make and receive payment has been reduced.

- (e) It is understood that the Public Aid Commission has requested the hospital association to accept an across-the-board reduction of 20 per cent in hospital bills."

Section (e) in the above paragraph was never instituted and, for that reason, should be ignored in the present discussion. The other regulations remained in full effect until November 27, 1953, at which time minor modifications were made. It had been hoped that these restrictions would be entirely done away with after the beginning of the present fiscal year, but, as is so often the case with governmental regulations, they have remained. In addition a letter dated November 18, 1953, has come from the executive office of the Public Aid Commission to various participating hospitals, and the drug restrictions (with certain modifications) which were placed on the physicians and druggists have now been placed on the hospitals when they care for recipients of public aid.

The question arises as to who it is that gets the majority of the monies paid out for "medical care." Who is it that receives the majority of the medical care under this program? What can we look for in the future in regard to this problem in our state?

In one county in June, 1953, the total monies paid for medical care to recipients of public aid was \$13,619.63; of that amount \$11,724.41 was paid for care of old age assistance recipients. That is, approximately 86 per cent of the total amount spent went for the care of people on old age assistance. Of the monies spent for the medical care of old age recipients, over half of it was spent for nursing home care, so that of the money spent for medical care over 40 per cent of the total amount was paid to nursing homes for care of old age assistance recipients.

In August, 1953, the same rural county spent about 76 per cent of the total monies for all public aid for the care of the old age assistance recipients. This means that, in this county, approximately 3½ per cent of the population received 76 per cent of the monies for public aid. In considering the history of the population of 65 years and older, we find that during the past 50 years their number has quadrupled and it has been predicted that by 1980 12 per cent of the population will be 65 years old or older.

The point of these statements is that the old age recipients already receive the bulk of the monies for public aid, and that we can estimate that during the years to come this amount of money of necessity must increase year after year if the present program is continued.

For the State of Illinois for the year 1951 of the entire monies spent by the Public Aid Commission for services listed as "medical care," less than 25 per cent were paid for physicians' services and drugs. These charges are often lumped together because many rural doctors dispense their own drugs and so bill for their services and drugs at the same time. The same situation held for the first five months of the fiscal year 1952. During the same periods, the amount of monies spent for "medical care" showed that approximately half of these expenditures went to nursing homes for the care of recipients in the nursing homes. The question then arises as to why it is necessary that all patients in nursing homes be charged in the bookkeeping as recipients of medical care. Almost any practicing physician knows that many of the old age recipients who are in nursing homes get little more than room and board, or room and board plus very minimal nursing service. Is it proper to charge this expense as a medical item? We understand that the reason for this is that all monies that the state spends for public aid recipients in their medical care are, in some way, matched by federal funds. Thus the larger the amount of their care that can be charged to medical care, the larger the amount of monies that can be obtained from the Federal Government. Further, it can be assumed, that the Federal Government would not contribute toward the care of recipients in a boarding home as such.

Paragraph three of the letter to Governor Stratton which was mentioned previously was worded as follows:

"The members of our society feel that the state government should review the entire situation as to the medical care for these people. If after such a review the state government wished to provide medical service for these individuals, then complete care should be provided over a long range program so that these people can receive the necessary care. If on the other hand the state government is not going to provide such

care, then such a policy should be announced and known to all parties concerned so that other arrangements can be made."

In addition it can be stated that other states have also had difficulties with administering public assistance. This was illustrated by witnesses before the House Ways and Means Subcommittee Fact Finding Hearing on Social Security. Representative Hruska from Nebraska and Phillip Vogt, Director of the Douglas County Welfare Administration in Omaha, testified that the program in Nebraska was being closed in regard to its medical care for public aid recipients, because of difficulty in coordination with the administration and the Federal Government. They recommended that the Federal Government end its participation in public assistance and turn over the problem to the state and local communities.

At the same committee hearing in Washington early in November, L. E. Rader, Director of the State Welfare in Oklahoma, testified that his state had found that the most logical way to handle its Aid to Dependent Children Program was through state and local action. Two research men, who had studied Louisiana's program, also testified that the old age assistance in this state is now considered a right of the aged rather than strictly an assistance.

The United States Chamber of Commerce has recommended to the Federal Government:

1. That they put presently unprotected aged on the Social Insurance rolls.
2. That they terminate Federal grants and leave to the states the small burden of supplementing the Social Insurance benefits with relief benefits in such cases as may be necessary.
3. They cut out the present Social Security

tax exemptions.

4. And they operate on a realistic pay-as-you-go basis.

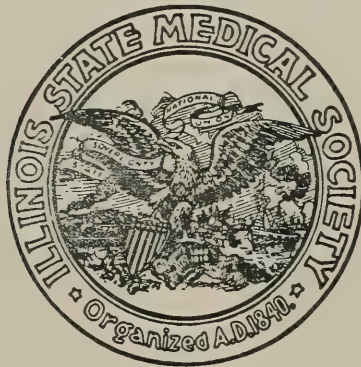
Representative Dr. Miller, who is in the United States House of Representatives, has recommended that a program almost identical to the one recommended by the Chamber of Commerce should be put into effect. In other words, the representatives of business throughout the United States have recommended that the Social Security program be extended to cover all aged individuals, and that the old age assistance program be done away with. In various states mentioned above similar feeling and recommendations have been noted. There is also some feeling in the United States House of Representatives that such a program should be followed.

In summary it can be said that the public aid program in Illinois is becoming increasingly complex. The paper work involved and the regulations and rules which must be observed increase regularly as the months go by. The majority of the individuals who receive this care are on old age assistance and their number will increase in the future without doubt. Other states have had problems similar to those that are present in Illinois.

It is suggested that the members of the constituent bodies of the Illinois State Medical Society should decide what programs they feel should be in effect so that their delegates at the state meeting will be so advised. It is suggested that the State Medical Advisory Committee also review the program in its entirety, and then make necessary recommendations for alterations or improvements in the Medical program of the Illinois Public Aid Commission.

119 S. Monroe

Preliminary Program  
One Hundred Fourteenth  
ANNUAL MEETING  
ILLINOIS STATE MEDICAL SOCIETY



Hotel Sherman, Chicago  
May 18, 19, 20, 21, 1954

# Program Plans for the 1954 Annual Meeting

The outline of section meetings and general assemblies for the 1954 annual meeting was revised by the Committee on Scientific Work in order to streamline the sessions and make it possible for the physicians in attendance to be present at as many of the section meetings, general assemblies and meetings of the House of Delegates as possible. The section meetings will be held Tuesday, Wednesday and Thursday mornings, and general assemblies will be scheduled each afternoon. The guest speakers at the morning section meetings will appear before the general assembly that afternoon.

The brief outline of the meeting is as follows:

## **Tuesday morning, May 18**

Section on Eye, Ear, Nose and Throat  
Section on Obstetrics and Gynecology  
Section on Cardiovascular Disease  
Section on Anesthesiology

## **Tuesday afternoon, May 18**

General Assembly

3:30 Section on Radiology — film reading session

## **Wednesday morning, May 19**

Section on Eye, Ear, Nose and Throat  
Section on Pediatrics  
Section on Surgery  
Section on Dermatology

## **Wednesday afternoon, May 19**

General Assembly

## **Thursday morning, May 20**

Section on Preventive Medicine and Public Health  
Section on Pathology  
Section on Allergy  
Section on Medicine

## **Thursday afternoon, May 20**

General Assembly

## **Friday morning, May 21**

Scientific movies arranged by Dr. Coye C. Mason, Chairman and Director of Scientific Exhibits for the Illinois State Medical Society.

The preliminary programs follow in the above order.

# Programs for Tuesday, May 18

## **SECTION ON EYE, EAR, NOSE AND THROAT**

Chairman: ..... **Earl H. Merz**, Chicago  
Secretary: ..... **Philip R. McGrath**, Peoria

### **Tuesday morning, May 18**

9:00-9:20—"Management of Exophthalmos in Thyroid Disease"

**G. Leroy Porter**, and **James S. Walker**,  
Carle Hospital Clinic, Urbana

9:20-9:30—Discussion

9:30-9:50—"Modern Ophthalmic Therapy by ACTH and Similar Compounds"

**Donald J. Boles**, Instructor, Department of

Ophthalmology, Northwestern University  
Medical School, Chicago

10:20-10:30—Discussion

10:30-11:00—"Some Interesting Oral Lesions"

**Russell A. Sage**, Assistant Professor of  
Otolaryngology, Indiana University  
School of Medicine, Indianapolis.

11:00-11:15—Discussion

11:15-11:30—Business meeting and election of  
Section Officers

11:30-12:00—RECESS to visit exhibits

## SECTION ON OBSTETRICS AND GYNECOLOGY

Chairman: . . James P. FitzGibbons, Chicago  
Secretary: . . Howard L. Penning, Springfield

**Tuesday Morning, May 18**

9:00-9:20—"Management of Varices in Pregnancy"

**Rocco V. Lobraico, Jr.**, Instructor, Department of Obstetrics and Gynecology, University of Illinois College of Medicine, Chicago

9:20-9:40—"Cesarean Section in a Small Hospital"

**William Curtis**, Chief of Staff, Memorial Hospital, Springfield

9:40-10:00—"Cytology: Its Practical Application in Gynecologic Diagnosis"

**Harold A. Grimm**, Assistant Professor of Pathology, University of Illinois College of Medicine, Chicago

10:00-10:30—RECESS to view exhibits

10:30-10:50—"Veratrine Derivatives in the Treatment of Toxemia of Pregnancy"

**Paul Raber**, Attending Obstetrician and Gynecologist, St. Mary's Hospital, Decatur

10:50-11:10—"The Rh Problem in Obstetrics"

**Joseph J. Mullen**, Instructor, Obstetrics and Gynecology, University of Illinois College of Medicine, Chicago

11:10-11:30—"Abnormal Uterine Bleeding in the Fortyish Woman"

**Frank M. Maher**, Instructor, Obstetrics & Gynecology, Northwestern University Medical School, Chicago

11:30—Business meeting and election of Section officers

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## SECTION ON CARDIOVASCULAR DISEASE

Chairman: . . . . . **Wright Adams**, Chicago

Secretary: . . . . . **V. Thomas Austin**, Urbana

**Tuesday morning, May 18**

9:00-9:20—"Recurrent Myocardial Infarctions"

**Chauncey C. Maher**, Associate Professor of Medicine, Northwestern University Medical School; Professor of Medicine, Cook County Postgraduate School, Chicago

9:20-9:40—"Multiple Drug Therapy in the Treatment of Hypertension"

**Edward W. Cannady**, Instructor in Clinical Medicine, Washington University School of Medicine (St. Louis, Missouri), East St. Louis

9:40-10:00—"Intractable Heart Failure"

**James A. Walsh**, President-Elect, Illinois Heart Association, Peoria

10:00-10:30—RECESS to view exhibits

10:30-11:00—"Present Status of Heart Surgery"

**Thomas J. Dry**, Professor of Medicine, University of Minnesota, Mayo Foundation; Head, Section on Cardiology, Mayo Clinic, Rochester, Minnesota

11:00-11:20—"Pathological Changes in Congestive Heart Failure"

**Oglesby Paul**, Clinical Associate Professor of Medicine, University of Illinois College of Medicine, Chicago

11:20—Business Meeting-election of section officers

11:30—Question and Answer Period

Doctors **Maher, Cannady, Walsh, Dry** and **Paul**.

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## SECTION ON ANESTHESIOLOGY

Chairman . . . . . **Max S. Sadove**, Chicago

Secretary . . . . . **Ernest J. Kreutzer**, Joliet

Alternate . . . . . **Arthur T. Shima**, Oak Park

**Tuesday morning, May 18**

9:00-9:20—"Clinical Experience with Oral Analgesics"

**Mary Karp**, Director of Anesthesiology, Wesley Memorial Hospital, Assistant Professor of Surgery, Northwestern University Medical School, Chicago

**Rosemary Susat**, Resident, Anesthesiology, Wesley Memorial Hospital, Chicago

9:20-9:40—"The Use of ACTH in Surgical Patients"

**William J. Grove**, Assistant Professor of Surgery, University of Illinois College of Medicine, Chicago

9:40-10:10—RECESS TO VISIT EXHIBITS

10:10-10:30—"Laudolissin—A New Synthetic Muscle Relaxant"

**Gordon M. Wyant**, Assistant Professor of Surgery (Anesthesia); Head of Division

of Anesthesia, Stritch School of Medicine of Loyola University; Director of Anesthesia, Mercy Hospital, Chicago

**Max S. Sadove**, Professor of Surgery, University of Illinois College of Medicine; Head, Division of Anesthesiology, Research and Educational Hospitals, Chicago

10:30-10:50—"Obstetrical Anesthesia"

**Lawrence D. Ruttle**, Staff Anesthesiologist, St. Joseph and Silver Cross Hospitals, Joliet

10:50-11:20—"The Electro-encephalogram in the Evaluation of the Effects of Antibiotic Agents"

**Henry E. Kretchmer**, Associate Professor of Anesthesiology, Western Reserve University, Director of Department of Anesthesiology, Cleveland City Hospital, Cleveland, Ohio

**George H. A. Clowes, Jr.**, Senior Instructor in Surgery, Western Reserve University, and Associate Visiting Surgeon, Cleveland City Hospital, Cleveland, Ohio

**Fiorindo A. Simeone**, Professor of Surgery, Western Reserve University School of Medicine, Cleveland, Ohio

11:20-11:40—"Chlorpromazine in General Anesthesia"

**Arthur T. Shima**, Division of Anesthesiology, Research and Educational Hospitals, Chicago

**Max S. Sadove**, Head, Division of Anesthesiology, Research and Educational Hospitals, Chicago

11:40—Business meeting to elect section officers

**GENERAL ASSEMBLY**

**Tuesday afternoon, May 18**

Presiding . . . . . **Earl H. Merz**, Chicago  
Assisting . . . . . **George Irwin, Jr.**, Bloomington

1:30-1:40—Opening of the General Assembly  
**Willis I. Lewis**, President, Illinois State Medical Society, Herrin

1:40-2:00—"Diagnosis and Treatment of Common Lesions of the Mouth"

**Russell A. Sage**, Assistant Professor of Otolaryngology, Indiana University School of Medicine, Indianapolis

2:00-2:20—"The Management of Threatened Abortion"

**Richard Paddock**, Assistant Professor of Clinical Obstetrics and Gynecology, Washington University School of Medicine, St. Louis, Missouri

2:20-2:40—"Problems Associated with the Roentgenologic Diagnosis of Certain Common Pulmonary Lesions"

**C. Allen Good**, Associate Professor of Radiology, Mayo Foundation Graduate School; Consultant Diagnostic Roentgenology Mayo Clinic, Rochester, Minnesota

2:40-3:10—RECESS TO VIEW EXHIBITS

Presiding . . . . . **V. Thomas Austin**, Urbana  
Assisting . . . . . **Max S. Sadove**, Chicago

3:10-3:30—"The Management of Pain"

**Daniel C. Moore**, Director of Anesthesia, Virginia Mason Hospital, Seattle, Washington

3:30-3:50—"Present Status of Heart Surgery"

**Thomas J. Dry**, Professor of Medicine, University of Minnesota, and Mayo Foundation; Head, Section on Cardiology, Mayo Clinic, Rochester, Minnesota

3:50-4:10—"What Lies Ahead in the Field of Nutrition"

**William J. Darby**, Professor and Head of Department of Biochemistry and Director of the Division of Nutrition, Vanderbilt University School of Medicine, Nashville, Tennessee

**SECTION ON RADIOLOGY**

Chairman . . . . **George Irwin, Jr.**, Bloomington  
Secretary . . . . . **E. Kenneth Lewis**, Chicago

**Tuesday Afternoon, May 18**

3:30 p.m.

The guest moderator for the film reading session of the **Section on Radiology** will be **Dr. C. Allen Good**, Associate Professor of Radiology, Mayo Foundation Graduate School, Consultant Diagnostic Roentgenology, Mayo Clinic, Rochester, Minnesota.

All physicians who are interested will be most welcome at this section meeting.

Business session and election of section officers will be followed by a Fellowship Hour.

# Programs for Wednesday, May 19

## SECTION ON EYE, EAR, NOSE AND THROAT

Chairman ..... **Earl H. Merz**, Chicago

Secretary ..... **Philip R. McGrath**, Peoria

**Wednesday morning, May 19**

9:00-9:20—"A Reference Point System of Interpreting Vestibular Tests"

**A. M. Paisley**, Jacksonville

9:20-9:30—Discussion

9:30-11:30—"SYMPOSIUM — Headache"

MODERATOR — **Watson Gailey**, The Gailey Eye Clinic, Bloomington

9:30-9:50—"Neurological Aspect"

**Eric Oldberg**, Head of Department of Neurology and Neuro-Surgery, University of Illinois College of Medicine, Chicago

9:50-10:10—"Systemic Aspect"

**Thomas Coogan**, Department of Medicine, Northwestern University Medical School, Chicago

10:10-10:30—"Psychiatric Aspect"

**Hugh Carmichael**, Professor of Psychiatry, University of Illinois College of Medicine, Chicago

10:30-10:50—"Ophthalmological Aspect"

**Kenneth Roper**, Associate Professor of Ophthalmology, Northwestern University Medical School, Chicago

10:50-11:10—"Otolaryngological Aspect"

**William McNicholas**, Dixon

11:10-11:30—Discussion

11:30-12:00—RECESS TO VIEW EXHIBITS

## SECTION ON PERIATRICS

Chairman ..... **James B. Gillespie**, Urbana

Secretary .... **Ralph H. Kunstadter**, Chicago

**Wednesday Morning, May 19**

### SYMPOSIUM ON CHRONIC DIARRHEA

9:00-9:15—"Surgical Implications of Chronic Diarrhea"

**Willis J. Potts**, Associate Professor of Surgery, Northwestern University Medical School; Surgeon in Chief, Children's Memorial Hospital, Chicago

9:15-9:30—"Bacterial Diarrhea"

**John P. Burgess**, Rock Island

9:30-9:45—"Parasitic Diarrhea"

**John D. Stull**, Olney

9:45-10:00—"Virus Diarrhea"

**Orville E. Barbour**, Peoria

10:00-10:30—RECESS TO VIEW EXHIBITS

10:30-10:45—"Gastrointestinal Allergy"

**Joseph B. Seagle**, Carle Hospital Clinic, Urbana

10:45-11:00—"Cystic Fibrosis of the Pancreas: Diagnosis and Treatment"

**Benjamin M. Kagan**, Chairman, Department of Pediatrics, Director of Pediatric Research, Michael Reese Hospital, Chicago

11:00-11:15—"Celiac Disease: Diagnosis and Treatment"

**John Lester Reichert**, Assistant Professor of Pediatrics, Northwestern University Medical School; Children's Memorial Hospital, Chicago

11:15-11:30—"Chronic Ulcerative Colitis and Regional Ileitis"

**Joseph B. Kirsner**, Professor of Medicine, University of Chicago School of Medicine, Chicago

11:30—Business meeting and election of section officers

11:40—Questions and Discussion

## LUNCHEON MEETING

of The

Illinois Chapter — American Academy of Pediatrics

**Wednesday noon, May 19**

## SECTION ON SURGERY

Chairman ..... **Arnell M. Vaughn**, Chicago

Secretary .... **Howard P. Sloan**, Bloomington

**Wednesday morning, May 19**

9:00-9:15—"Surgical Aspects of Gout"

**James Keane Stack**, Associate Professor of Bone and Joint Surgery, Northwestern University Medical School; Attending Orthopaedic Surgeon, Passavant Memorial Hospital, Chicago

**William A. Larmon**, Attending Orthopaedic Surgeon, Passavant Memorial Hospital, Chicago

9:15-9:30—"Revascularization of the Ischemic Extremity"

**Geza deTakats**, Clinical Professor of Surgery, University of Illinois College of Medicine; Senior Attending Surgeon, St. Luke's Hospital, Chicago

9:30-9:45—"Certain Aspects of the Treatment of the Acute Traumatic Chest"

**Ray W. Fricke**, Joliet

9:45-10:00—"Lesion of the Jejunum as the Cause of Obscure Upper Gastro Intestinal Hemorrhage"

**Benton Holm**, (Former Assistant Professor of Surgery, College of Medicine, University of Vermont), Moline  
**Loren Helfrich**, Moline

10:00-10:30—RECESS TO VIEW EXHIBITS

PANEL DISCUSSION ON **ABDOMINAL PAIN**

Moderator — **Arkell M. Vaughn**, Chicago

10:30-10:40—"Significance of Pain in Gall Bladder Disease"

**Charles D. Branch**, Peoria

10:40-10:50—"Diagnostic Significance of Gastro Intestinal Pain"

**Harry A. Oberhelman**, Professor and Chairman, Department of Surgery, Stritch School of Medicine of Loyola, Chicago

10:50-11:00—"Nonpenetrating Abdominal Injuries"

**Chester C. Guy**, Clinical Associate Professor of Surgery, University of Illinois College of Medicine, Chicago

11:00-11:10—"Gynecological Aspects of Lower Abdominal Pain"

**Thomas B. Wilson**, Carle Hospital Clinic, Urbana

11:10-11:30—Panel Discussion

Election of Section officers at business meeting.

## **SURGICAL SECTION LUNCHEON**

**Wednesday noon, May 19**

Reservations may be made with **Dr. Howard P. Sloan**, Secretary, Section on Surgery, 203 North Main Street, Bloomington, Illinois

## **SECTION ON DERMATOLOGY**

Chairman . . . . . **Francis E. Senear**, Chicago  
Secretary . . . . . **Malcolm Spencer**, Danville

**Wednesday morning, May 19, 1954**

Program to come

## **GENERAL ASSEMBLY**

**Wednesday afternoon, May 19**

Presiding . . . . . **Arkell M. Vaughn**, Chicago  
Assisting . . . . . **Malcolm Spencer**, Danville

1:30-1:50—"Hydrocortone Ointment in Dermatology: Its Effectiveness and Limitations"

**Clarence S. Livingood**, Physician in Charge, Division of Dermatology, Henry Ford Hospital, Detroit, Michigan

1:50-2:20—**ORATION IN SURGERY: The Cancer-Ulcer Problem of the Stomach"**

**J. Dewey Bisgard**, Professor of Surgery, University of Nebraska College of Medicine, Omaha, Nebraska

2:20-2:45—PRESIDENT'S ADDRESS:

**Willis I. Lewis**, President, Illinois State Medical Society, Herrin.

2:45-3:15—RECESS TO VIEW EXHIBITS

Presiding . . . . . **James B. Gillespie**, Urbana  
Assisting . . . . . **Ralph H. Kunstadter**, Chicago

3:15-3:55—"Surgical Treatment of Coronary Arterial Heart Disease"

**Charles P. Bailey**, Professor of Thoracic Surgery, Hahnemann Hospital, Philadelphia, Pennsylvania

3:35-3:55—"Some Comments on X-Ray Diagnosis in Pediatrics"

**Frederic N. Silverman**, Associate Professor of Radiology, Assistant Professor of Pediatrics, University of Cincinnati College of Medicine; Director, Department of Radiology, Attending Pediatrician at Children's Hospital, Cincinnati, Ohio

3:55-4:15—"Congenital Anomalies of the Tracheobronchial Tree"

**Paul H. Holinger**, Professor of Bronchoesophagology, University of Illinois College of Medicine, Chicago

# Programs for Thursday, May 20

## SECTION ON PREVENTIVE MEDICINE & PUBLIC HEALTH

Chairman ..... **Leroy L. Fatherree**, Joliet  
Secretary ..... **R. F. Sondag**, Murphysboro

Thursday morning, May 20

9:00—"Prophylactic Effect of Gamma Globulin  
in Acute Anterior Poliomyelitis During  
1953"

**Leonard M. Schuman**, Deputy Director,  
Division of Preventive Medicine, Depart-  
ment of Public Health, State of Illinois,  
Springfield.

"Advances in Vaccine for Prevention of  
Acute Anterior Poliomyelitis"

**Jonas E. Salk**, Pittsburgh, Pennsylvania  
**H. J. Shaughnessy, Ph.D.**, Chicago

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"Evaluating Field Trials of Vaccine for  
Prevention of Acute Anterior Poliomyeli-  
tis."

**Thomas B. Francis**, Ann Arbor, Michigan

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### Joint Luncheon

Section on Preventive Medicine and Pub-  
lic Health, Illinois Association of Medical  
Health Officers

Please make reservations through Dr. Herbert  
Ratner, 129 Lake Street, Oak Park, Illinois.

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## SECTION ON PATHOLOGY

Chairman ..... **Coye C. Mason**, Chicago  
Secretary ..... **Franklin J. Moore**, Chicago

Thursday morning, May 20

9:00-9:15—"The Interpretation of Routine Blood  
Counts"

**Keith Truemner**, Rockford

9:15-9:20—Discussion

9:20-9:35—"The Appendix, the Pathologist,  
and the Surgeon"

**Coye C. Mason**, Assistant Professor of  
Pathology, University of Illinois College  
of Medicine; Pathologist, Grant Hospital,  
Chicago

9:35-9:40—Discussion

9:40-9:55—"One Foot at the Bedside"

**Joseph D. Boggs**, Evanston

9:55-10:00—Discussion

10:00-10:55—REPORTS ON STUDIES BEING  
MADE BY RESIDENTS IN PATHOLOGY:

10:00-10:10—"Cytologic Diagnosis of Lower  
Colon Diseases from Lower Colon Wash-  
ings"

**Leo Reilly**, St. Francis Hospital, Evanston

10:10-10:15—Discussion

10:15-10:25—"Infarction of Right Cardiac Ven-  
tricle the Result of Stenosis of Right Coro-  
nary Artery Caused by Foreign Body  
("BB" Shot), in Lumen of Coronary Ar-  
tery"

**Fred D. Dallenbach**, Department of Path-  
ology, University of Illinois College of  
Medicine, Chicago

10:25-10:30—Discussion

10:30-10:40—"A Study of Cross Circulation  
and Tissue Reactions at Parabiotic Junc-  
tions"

**Richard H. Andresen**, Department of  
Pathology, Presbyterian Hospital, Chi-  
cago.

10:40-10:45—Discussion

10:45-10:55—"Complete Transposition of Main  
Branches of Blood Vessels of Heart with  
Patent Foramen Ovale in a Male Indi-  
vidual Eighteen Years of Age".

**Simao Pung**, Department of Pathology,  
St. Luke's Hospital, Chicago

10:55-11:00—Discussion

11:00-11:30—"Recent Advances in Laboratory  
Diagnosis of Viral Diseases"

**Albert Milzer, M.D., Ph.D.**, Director, Micro-  
biology Laboratory, Michael Reese Hos-  
pital, Chicago

11:30-11:35—Discussion

11:35-11:45—"Transfusion Therapy: Progress  
and Problems"

**Kurt Stern**, Director, Blood Center, Mt.  
Sinai Research Foundation and Hospital,  
Chicago

11:45-11:50—Discussion

11:50-12:00—"Observations of Past President  
of Illinois Society of Pathologists Regarding  
Conduct of Pathology in Illinois"

**Coye C. Mason**, Chicago

12:00—Election of Section officers

## LUNCHEON AND BUSINESS MEETING

Illinois Society of Pathologists

Please make luncheon reservations with  
**Dr. J. J. Kearns**, Program Chairman, Illinois  
Society of Pathologists, 1431 North Claremont  
Avenue, Chicago 22, Illinois

## SECTION ON ALLERGY

Chairman ..... **Morris A. Kaplan**, Chicago  
Secretary ..... **Ellis A. Canterbury**, Peoria

Thursday morning, May 20

9:00-9:20—"Allergy and the Pediatrician"

**Morris A. Kaplan**, Assistant Professor of  
Medicine, Chicago Medical School, Chi-  
cago

9:20-9:40—"The Value of Skin Tests in Al-  
lergy"

**Max Samter**, Associate Professor of Medi-  
cine (Allergy Unit), University of Illinois  
College of Medicine, Chicago

9:40-10:00—"Useful Drugs in the Treatment of  
Allergy"

**Samuel Feinberg**, Professor of Medicine  
and Head of Allergy, Northwestern Uni-  
versity Medical School, Chicago

10:00-10:30—"Practical Aspects in the Man-  
agement of Food Allergy"

**Theron G. Randolph**, St. Francis Hospital,  
Evanston

10:30-11:00—RECESS FOR VIEWING EX-  
HIBITS

11:00-11:30—"Drug Eruptions (Mechanisms of  
Cutaneous Drug Eruptions)"

**A. Rostenberg**, Professor of Dermatology  
(Allergy Unit) University of Illinois Col-  
lege of Medicine, Chicago

11:30-11:50—"The Otolaryngologists Look to  
Allergy"

**Eugene L. Derlachi**, Instructor in Oto-  
laryngology, Northwestern University  
Medical School, Chicago

11:50-12:00—Business meeting and election of  
Section Officers

Section on Allergy and Chicago Society  
of Allergy

**LUNCHEON — Thursday noon, May 20**

Please make luncheon reservations with  
**Dr. Morris A. Kaplan**, Chairman, 116 South  
Michigan Avenue, Chicago 3, Illinois

## SECTION ON MEDICINE

Chairman ..... **Hugh A. Flack**, Chicago  
Secretary .... **George Mason Parker**, Peoria

Thursday morning, May 20

9:00-9:20—"Problems in Antibiotic Therapy"

**Harry F. Dowling**, Professor of Medicine,  
Head of Department of Medicine, Uni-  
versity of Illinois College of Medicine,  
Chicago

9:20-9:40—"Strokes"

**Lewis J. Pollock**, Professor Emeritus, De-  
partment of Nervous and Mental Dis-  
eases, Northwestern University Medical  
School, Chicago

9:40-10:00—"Psychiatric Implications of Aller-  
gic Disease"

**Irving L. Turow**, Peoria

10:00-10:30—RECESS TO VIEW EXHIBITS

10:30-10:50—"Anticoagulant Therapy"

**Ovid O. Meyer**, Professor of Medicine,  
University of Wisconsin, University Hos-  
pitals, Madison, Wisconsin

10:50-11:10—

**H. Marvin Pollard**, Associate Professor of  
Internal Medicine, University of Michigan  
Medical School, Ann Arbor, Michigan

11:10-11:30—"Recognition and Diagnosis of  
Diabetes Mellitus"

**Lucille Sprenger**, Peoria

11:30-11:45—Business Meeting and election of  
section officers

## GENERAL ASSEMBLY

Thursday afternoon, May 20

Presiding ..... **George Mason Parker**, Peoria

Assisting ..... **Coye C. Mason**, Chicago

1:30-1:50—"Transfusion Therapy: Progress  
and Problems"

**Kurt Stern**, Director, Blood Center, Mt.  
Sinai Medical Research Foundation, Chi-  
cago

1:50-2:20—ORATION IN MEDICINE: Hemor-  
rhage from the Upper Gastro-Intestinal  
Tract."

**Marvin Pollard**, Associate Professor of  
Medicine, University of Michigan, Uni-  
versity Hospital, Ann Arbor, Michigan

2:20-2:40—"Epidemic Intelligence"

**Leonard W. Schuman**, Deputy Director,  
Division of Preventive Medicine, Illinois  
State Department of Public Health,  
Springfield

2:40-3:10—RECESS TO VIEW EXHIBITS

Presiding ..... **Morris A. Kaplan**, Chicago

Assisting ..... **Ellis A. Canterbury**, Peoria

3:10-3:30—"Treatment of the Lymphoblasto-  
mas"

**Ovid O. Meyer**, Professor of Medicine,

University of Wisconsin, University Hospitals, Madison, Wisconsin  
3:30-3:50—"Allergy and the General Practitioner"

**Ethan Allen Brown**, Assistant Professor of Pediatrics, Tufts College Medical School; Physician in Chief, Allergy Clinic, Boston Dispensary Unit of New England Medical Center; Director, Asthma Research Foundation; Editor, *Annals of Allergy*; Editor,

*Folia Clinica Internacional*; Editor, *International Archives of Allergy and Applied Immunology*, Boston, Massachusetts

3:50-4:10—"Integration of a Neuropsychiatrist in the Medical Team of the General Hospital"

**Benjamin Boshes**, Professor and Head of Department of Nervous and Mental Diseases, Northwestern University Medical School, Chicago

## *Program for Friday, May 21*

**SCIENTIFIC MOVIES** — Arranged by **Doye**

**C. Mason**, Chairman and Director of Sci-

entific Exhibits

Final Session of the House of Delegates

## *General Information*

The Executive Committee, whose responsibility it is to provide the scientific programs for the General Assemblies is composed of

Chairman: **Hugh A. Flack**, Chicago

Vice-Chairman: **Earl H. Merz**, Chicago

Secretary: **Morris A. Kaplan**, Chicago

Assistant-Secretary: **Ralph H. Kunstadter**, Chicago

Before sessions of the General Assembly will be presented (1) The President's Address given by Willis I. Lewis of Herrin, president of the Illinois State Medical Society, (2) The Oration in Medicine and (3) the Oration in Surgery. The two orators are invited guests of the officers of the state society.

**SESSIONS OF THE HOUSE OF DELEGATES** will be held on Tuesday morning, late Thursday afternoon, and early Friday morning, in order to avoid conflict with the scientific programs as much as possible. The meetings of the reference committees of the House will be held on Wednesday, and whenever necessary, on Thursday morning, in order to complete the work assigned by the House.

Many of the various sections will have luncheons following their morning sessions, and the committees are arranging to have the best room accommodations possible for each meeting. The hotel assures us that the personnel will cooperate in every way to provide the best set up for each meeting. Rooms will be darkened so that slides and movies can be viewed easily.

**SOCIAL FUNCTIONS:** The annual dinner will be held on Wednesday evening to honor the retiring president, Dr. Willis I. Lewis of Herrin. The speaker at the annual dinner will be Dr. Nicholas P. Dallis of Toledo, Ohio, the creator of the comic strip REX MORGAN, M. D. The members of the Fifty Year Club will be guests of the society at their annual luncheon on Wednesday noon. The Public Relations Dinner is tentatively scheduled for Thursday evening, and each county medical society is asked to send representatives to this affair. Any physician attending the annual meeting will be most welcome.

**PROGRAM MATERIAL** will be printed in full in the April and May issues of the *Illinois Medical Journal*.

### **Local Committees on Arrangements**

**Dr. Louis R. Limarzi** as General Chairman of the Committee on Arrangements, and his Vice-Chairman, **Mr. Maurice M. Hoeltgen**, have announced the appointment of the following local committees:

#### **Advisory Committee**

Chairman: **Fred H. Muller**, Chicago

Vice Chairman, **Leo P. A. Sweeney**, Chicago

**F. Lee Stone**, Chicago

**G. Henry Mundt**, Chicago

**Charles P. Blair**, Monmouth

**George E. Kirby**, Spring Valley

**Frank H. Fowler**, Chicago

**Warren H. Cole**, Chicago

**Lowell T. Coggeshall**, Chicago

**Richard H. Young**, Chicago

Edwin S. Hamilton, Kankakee  
 Roland R. Cross, Springfield  
 Harlan English, Danville  
 Percy E. Hopkins, Chicago  
 Warren W. Furey, Chicago  
 Walter C. Bornemeier, Chicago  
 John F. Sheehan, Chicago  
 Earl Garside, Chicago  
 Elmer V. McCarthy, Chicago

#### **Committee on Registration and Information**

Chairman: **Holger Hoegh**, Chicago

Vice Chairman: **Fred J. Stucker**, Chicago

Charles W. Bibb, Chicago  
 Leonidas Berry, Chicago  
 Maurice V. Puckey, Chicago  
 Robert R. Mustell, Chicago  
 Edward A. Christofferson, Chicago  
 A. C. Wendt, Jr., Chicago  
 Richard L. Landau, Chicago  
 William A. Hutchison, Chicago  
 John B. Condon, Chicago  
 Robert E. Field, Blue Island  
 Gene S. Wong, Chicago  
 Charles P. Eck, Chicago  
 H. L. Wallin, Chicago  
 E. Allen Parsons, Chicago  
 William J. Blackwell, Evanston  
 Edward A. Grabar, Chicago  
 W. B. Stromberg, Chicago  
 Walter A. Dziuk, Chicago  
 Martha Rubin Folk, Chicago  
 Joseph M. Ruda, Chicago  
 Joseph H. Buckley, Chicago

#### **Reception Committee (Hospitality Night)**

Chairman: **F. M. Nicholson**, Chicago

Vice Chairman: **Allison L. Burdick, Sr.**,  
 Chicago

Gustav L. Kaufman, Chicago  
 John H. Garwacki, Chicago  
 John V. Fowler, Jr., Chicago  
 John C. Wall, Chicago  
 Michael Boley, Chicago  
 Warren W. Young, Chicago  
 Pliny R. Blodgett, Chicago Heights  
 Jack W. Fischer, Chicago  
 Willard O. Thompson, Chicago  
 Charles D. Krause, Chicago  
 Michael J. Kutza, Chicago  
 G. Henry Mundt, Jr., Chicago  
 W. Walter Sittler, Chicago

Robert A. Arens, Chicago  
 M. M. Hippskind, Chicago  
 John E. Siedlinski, Chicago  
 Fred A. Tworoger, Chicago  
 Andrew J. Sullivan, Chicago  
 Paul L. Bedinger, Evanston

#### **Women Physicians' Committee**

To plan complimentary breakfast for  
 women physician registered at the meet-  
 ing

Chairman: ..... **M. Alice Phillips**, Chicago

Vice Chairman:

..... **Evangeline Stenhouse**, Chicago  
**Marguerite G. Oliver**, Chicago

#### **Annual Dinner Committee**

Chairman: .... **H. Close Hesseltine**, Chicago

Vice-Chairman: **Patrick H. McNulty**, Chicago

**George A. Hellmuth**, Chicago  
**Charles S. Vil**, Chicago  
**Roy M. Hohman**, Chicago  
**George L. Pastnack**, Park Ridge  
**Caesar Portes**, Chicago  
**John J. Brosnan**, Chicago  
**Anthony J. Bertash**, Chicago  
**Harry H. Stephens**, Oak Park  
**Norman M. Frank**, Clarendon Hills  
**Robert L. Craig**, Evanston  
**Andrew J. Brislen**, Chicago  
**N. F. Kupferberg**, Chicago  
**R. C. Aiken**, Blue Island  
**Nicholas J. Balsamo**, Chicago

#### **Publicity Committee**

Chairman: ..... **Jerome T. Paul**, Chicago

Vice Chairman: ..... **John R. Wolff**, Chicago

**Theodore R. VanDellen**, Chicago  
**Clarence C. Saelhof**, Chicago  
**Raleigh C. Oldfield**, Oak Park  
**Norris J. Heckel**, Chicago  
**Harry M. Hedge**, Chicago  
**James P. FitzGibbons**, Chicago  
 Secretary: .... **Mr. James C. Leary**, Chicago

#### **Technical Exhibits Committee**

Chairman: ..... **Earl H. Blair**, Chicago

Vice Chairman: .... **Noel G. Shaw**, Evanston

**L. E. Lundgoot**, Chicago  
**Wright Adams**, Chicago  
**Clarence K. Jones**, Chicago  
**Willard W. Fullerton**, Sparta  
**Walter A. Lawrence**, Berwyn

Karl L. Vehe, Chicago  
George C. Turner, Chicago  
Arthur F. Goodyear, Decatur

Burtis E. Montgomery, Harrisburg  
Edward A. Piszczek, Chicago  
George Milles, Oak Park

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## *Technical Exhibitors*

The following firms will be with us again this year. They have already made booth reservations, and physicians in attendance at the meeting will have ample time provided to visit all exhibits during the four days of the session.

The Abbott Laboratories  
A. S. Aloe Company  
The American Hospital Supply Corporation  
American Limb, Inc.  
The A. S. Aloe Company  
Ayerst, McKenna & Harrison, Ltd.  
Baby Development Clinic  
Baker Laboratories, Inc.  
Beech-Nut Packing Company  
The Blue Cross Plan for Hospital Care  
George A. Breon & Company  
Brown & Williamson Tobacco Corporation  
The Cameron Surgical Specialty Company  
Chicago Pharmacal Company  
Chicago Reference Book Company  
Ciba Pharmaceutical Products Company  
The Coca Cola Company  
Coles Electronic Corporation  
The Daniels Surgical Company  
Eisele & Company  
Eli Lilly & Company  
Encyclopaedia Americana  
Encyclopaedia Britannica  
The H. G. Fischer Company  
Freeman Manufacturing Company  
General Electric Company  
General Foods Corporation  
The H. J. Heinz Company  
Kremers-Urban Company  
Lederle Laboratories  
Liesel-Flarsheim Company  
Lincoln Laboratories

The J. B. Lippincott Company  
P. Lorillard Company  
Massachusetts Indemnity Insurance Company  
M & R Dietetic Laboratories  
Mead Johnson & Company  
Medco Products Company  
Medical Aids Incorporated  
Medical Arts Supply Company  
The Medical Protective Company  
Miles Reproducer Company  
Miller Surgical Company  
V. Mueller & Company  
National Drug Company  
Parke Davis & Company  
Charles Pfizer and Company  
R. J. Reynolds Tobacco Company  
A. H. Robins Company  
J. B. Roerig and Company  
The Sanborn Company  
Sandoz Chemical Works, Inc.  
The W. B. Saunders Publishing Company  
Schenley Laboratories  
The Schering Corporation  
Julius Schmid, Incorporated  
G. D. Searle & Company  
Sharp & Dohme  
Sherman Laboratories  
Smith, Kline & French Laboratories  
E. R. Squibb & Sons  
Standard Air Service Company  
The Upjohn Company  
U. S. Vitamin Corporation  
Varick Pharmacal Company  
Walden Industries, Inc.  
Walton Laboratories, Inc.  
Winthrop-Sterns, Inc.  
F. E. Young & Company  
Zemmer Company

# Woman's Auxiliary

The Woman's Auxiliary to the Illinois State Medical Society will have its annual meeting at the Hotel Sherman with the Society again this year. The following letter is addressed to the membership:

Dear Doctor:

It is the good fortune of the Auxiliary to meet once again at your headquarters, at the Hotel Sherman, Chicago. DO BRING YOUR WIFE ALONG!

Our 26th Annual Convention will be packed full of interesting meetings, and the most graciously planned events that result from the convention chairman, Mrs. B. K. Lazarski, and her active committee. Do watch for the entire agenda to be published in the next month's Journal, and mark your calendar for a really excellent meeting that will begin May 17, and run through to the 20th.

On Monday, May 17, Mrs. Henry Christensen will preside over the Preconvention Board

Meeting. On Tuesday, May 18, an elegant fashion show to be shown at Tea at the Lake Shore Athletic Club overlooking Lake Michigan. And to make plans even more interesting Mrs. H. Close Hesseltine is busy arranging for a beautiful luncheon at the Hotel Sherman on May 20. Please note that this schedule allows for the ladies to attend the Annual Dinner on Wednesday evening with our husbands.

For an outstanding convention, which will only be made so by the usual large attendance, we most cordially invite each and every doctor's wife to accompany her husband to Chicago in May.

See you in Chicago May 17, 18, 19, 20.  
Mrs. B. K. Lazarski  
Convention Chairman

Mrs. Nicholas G. Chester  
Convention Press Chairman

# THE P.R. PAGE



## P.R. DINNER

The second annual public relations dinner will be given during the annual meeting for county society public relations chairmen.

The date set is Tuesday, May 18, at the Hotel Sherman.

The Committee on Medical Service and Public Relations asks all county society secretaries who have not yet forwarded the names of their P.R. chairmen to do so as soon as they are chosen.

## REINSURANCE ISSUE

The Committee on Legislation of the American Medical Association held a regional meeting February 6 in the American Medical Association's headquarters for representatives from Minnesota, Wisconsin, Michigan, Indiana and Illinois. With Dr. Harlan English of Danville as chairman, the group heard reports and discussions of the various legislative issues, old and new, now confronting the medical profession.

A major topic was reinsurance, recommended by President Eisenhower in his health message in January. The president said that \$25,000,000 in federal funds should be appropriated to make it possible for the various insuring agencies to reinsure each other against excessive losses and thus increase benefits to take care of catastrophic illness.

The delegates were unanimously opposed to the scheme. The trustees of the American Medi-

cal Association have not adopted a formal attitude on it, because so far there is no bill designated specifically as the administration's plan, but there was no doubt of individual medical opinion.

While the president's ideas have not yet been spelled out, the Wolverton bill (HR 6949) is reported to embody them in general. It would provide a federal initial sum of \$50,000,000 to start operation and take 2 per cent of the gross receipts of any voluntary nonprofit health insurance company participating. For that it would repay to the company two-thirds of any claim over \$1,000.

Discussants pointed out, in the first place, that reinsurance by government is unnecessary. It is already accepted practise among insurance companies.

Further, speakers said that in a recent poll of insurance plans, \$1,000 claims were reported to be extremely few, so many plans would be paying a 2% premium for nothing.

One speaker observed that the plan merely extends insurance to uninsurables, who should be cared for out of their own or public funds, not by insurance. It means, he said, an extra 2% levied on persons who can afford insurance for the benefit of those who cannot.

"The doctors," said Tom Hendricks, secretary of the American Medical Association Council on Medical Service, "are again about to be thrown to the Wolvertons."

## UNITY OF MEDICAL OPINION

Dr. David B. Allman of Atlantic City, N. J., trustee of the American Medical Association, made a forceful plea for unity of medical opinion at the legislative conference.

The trustees, he pointed out, study each legislative issue carefully and thoroughly on its merits and then adopt a formal position in the light of the facts and the best interests of public and profession. Then one man is usually designated to present that opinion at a hearing on the bill in Washington.

However, Dr. Allman continued, it is not unusual for some congressman to pull out a letter from a physician back home expressing an opinion opposite to that of the American Medical Association. The medical spokesman is thus embarrassed and the value of his statement weakened.

Everyone has a right to his opinion, of course, Dr. Allman said, but if he wants it reflected in the profession's formal announcements, the place to write is the American Medical Association.

"We would like every member to support our position with letters to his own congressman," Dr. Allman said. "That is the most effective method of expression, for every representative pays attention to word from his voters. But those who disagree with the opinion of the board should write to us. We are doing our best to reflect medical opinion and we want such letters."

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## DON'T BE A MULE!

Mules, they say, have neither pride of ancestry nor hope of posterity. The non-mule has both and thus he is interested in the history accumulated by his ancestors and in preserving the achievements of his own generation for his successors.

That brings up the Committee on Medical History of the Illinois State Medical Society, which is interested in recording the history of medicine in Illinois. Several years back, it recommended to the secretaries of county medical societies throughout the state that each write annually for the archives a summary of the work

of his society for the year, giving a list of members, and other details, together with the facts of health and medical care in his jurisdiction.

That is still a good idea.

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## PRESS CODES — PRO AND CON

A press code proposed to the New York State Society of Newspaper Editors by the New York State Medical Society was turned down cold by the editors recently at a meeting in Buffalo.

"As a matter of fact," one editor said, "the press has been too kind to the medical profession. . . . Why should we be a party to engineering something that gags our doctor friends in their relationship with reporters?"

Editors apparently resented the implication that they needed a code to protect the patient's life, health or rights or to bar from print material designed to exploit a doctor, patient or hospital. One doubted that there is "any codified substitute for good judgment."

However, they agreed to name a committee to meet over a new draft of the code.

The New York editors' blasts at the medical profession reflect one facet of press opinion that must be taken into consideration — the editorial resentment against any restrictions on publication beyond their own standards of taste and propriety. In most cases, probably, these are sufficient, but they still do not coincide with the professional secrecy which is an integral part of the physicians' code. Clashes are thus inevitable.

In fact, code or no code, only intelligent forbearance on both sides, based on sincere efforts at mutual understanding of standards and problems, can preserve harmony.

The same issue of Editor and Publisher which reported the New York episode carried an article describing the code now in effect in Macon County, Illinois, which illustrates vividly the benefits of mutual forbearance and understanding.

Codes must be fully agreeable to both sides and carefully adapted to local conditions, as in the Decatur case. Otherwise, like most laws, they merely make more business for the lawyers.

# KNOW YOUR SOCIETY



## COUNCIL COMMITTEES (continued)

*Committee on Physical Medicine and Rehabilitation.* The Committee on Physical Therapy has been one of the appointed Council committees for many years. In the 1952-1953 fiscal year, a letter from one of the members of the committee made the suggestion that the committee's name be changed to "The Committee on Physical Medicine and Rehabilitation" so that the label applied to this group would coincide more favorably with the work it is called upon to do.

The Committee has furnished abstracts of writings on Physical Medicine and Rehabilitation for publication in the Illinois Medical Journal. All current literature has been reviewed and significant material selected to keep the membership of the Society informed through the pages of the Journal each month.

*Committee on Postgraduate Education.* Providing postgraduate facilities for the membership of the Society is one of the most important functions of the State Medical Society. For no cost, other than the payment of dues, the Committee on Postgraduate Education has attempted to bring to physicians the type of postgraduate program most needed, the subject desired by the local men presented by the physicians best qualified scientifically to present these subjects.

Under the present chairman a serious and concentrated attempt has been made to blend together the various factions presenting post-

graduate programs throughout Illinois, and to work in close cooperation with the Illinois Chapter of the American Academy of General Practice, the Illinois Heart Association, etc. The five medical schools in the Chicago area have presented postgraduate conferences throughout the downstate area; the teaching hospitals have worked with the committee to develop programs and subjects for conference presentation. Nearly 100 physicians participated in the committee work during the past fiscal year.

In cooperation with other interested groups a careful survey of the postgraduate needs in Illinois is being considered by the committee. Such a study would be important as a basis for planning coordinated and expanded postgraduate programs in Illinois, and would also have national significance as research in this field.

There are many questions in the field of postgraduate education with which the committee has to deal. Who is basically responsible for providing postgraduate opportunity — organized medicine, the medical schools, government agencies, medical specialty groups, voluntary agencies? Should a fee be charged? Is the day-long meeting the best method of presentation? Should teachers spend a week at a time in a local hospital? Should "circuit-riders" be kept on the road? In a telephone roundtable hookup a good method? Will TV channels be allotted to medical teaching, and if so, what use should be made

of them? What subjects should be covered, and who is to plan the material, the speakers, etc.? Where is the need for medical postgraduate education most acute?

The Committee works in close cooperation with the Council, and through the expression of opinion from each Councilor representing a different section of the State, tries to develop the best program for the most members of the medical profession in any one given area.

The activities of this committee and the services it brings to each physician are all a part of "what you get for your dues" in the Illinois State Medical Society.

*Committee on Scientific Exhibits.* Perhaps this is a committee about which the average member of the Illinois State Medical Society knows very little. It is composed of a Chairman and Director of Scientific Exhibits, and a member from each of the five medical schools in the state. The committee is charged with the development and presentation of the scientific exhibits at the annual meeting of the Illinois State Medical Society. Each year this committee and its work represents a financial investment of state medical society funds of over \$6,000.00. No exhibitor in this field is asked to contribute to this overhead; he is provided with space, and the expense of booths, back-drops, signs, lighting, etc., is assumed by the State Society.

The outstanding quality of the work of this committee can best be brought home to the membership by stating that many of the exhibits it selects and helps to present to those in attendance at the annual meeting, go on to win recognition at meetings of the American Medical Association.

The committee is very interested in securing exhibits from downstate physicians for the 1954 annual meeting. Applications for exhibit space can be secured by any physician by writing to Dr. Coye C. Mason, Chairman and Director, 551 Grant Place, Chicago. Your application will secure serious consideration by the committee.

May we suggest that during the 1954 annual meeting at the Hotel Sherman, Chicago, May 18, 19, 20, 21, those physicians in attendance arrange to visit the scientific exhibit booth, allowing ample time to appreciate the effort and expense which goes into the development of this scientific material for the education and edification of all members.

*Committee on Rural Medical Service.* The development of the Committee on Rural Medical Service resulted, fundamentally, from the organization of the Student Loan Fund in cooperation with the Illinois Agricultural Association. Under the agreement between these two organizations, each is contributing \$50,000 over a ten year period to be loaned to medical students on certain conditions. The recipients of loans from the Student Loan Fund agree to return to their home county to practice general medicine. They must be recommended by their local Farm Bureau and their local Medical Society. There are approximately 50 young people receiving their education with assistance from these funds. They represent counties in the state of Illinois where the physician-population ratio is high and additional medical personnel is needed. When they graduate from medical school and enter the practice of medicine throughout the state, they should be loyal and active members of organized medicine, and should never have to be told of the services which are part and parcel of belonging to organized medicine.

This Committee on Rural Medical Service has worked to develop County Health Improvement Associations in the various counties throughout the state. A Health Improvement Association is virtually the equivalent to a community health council since various health measures can be instituted, formulated and brought to a successful conclusion by this organization. This group also provides an excellent means of providing hospital and medical insurance. H.I.A. groups have worked to recruit young women to enter the nursing profession, to improve local health conditions, etc., and the cooperation of the county medical society, as well as individual physicians, helps to develop good public relationship at the local level.

The chairman of this committee, Dr. Harlan English, 139 North Vermilion Street, Danville, has been active since the committee was organized; the work of the Student Loan Fund has been carried on under his guidance. The future improvement of medical care in the rural areas is the responsibility of this group, and the aim of the committee personnel.

*Scientific Service Committee.* The Scientific Service Committee, (originally almost a sub-committee of the Educational Committee) was

the outgrowth of a demand from county medical societies for assistance in planning and developing scientific programs for regular society meetings. The requests for assistance from this committee, headed by Dr. Louis R. Limarzi, 1853 West Polk Street, Chicago, must originate at the county level. The committee should be contacted either by the county society officers, or by the local program chairman. Ample time should be given to the committee to fill any request for a speaker.

Last year 69 speakers were scheduled to speak before 24 different county medical societies, speakers were furnished branch societies of the Chicago Medical Society; speakers were supplied for hospital staff meetings, etc.

At the present time the committee is developing a speakers' file composed of a cross file by speakers and subjects, which will be published for distribution to officers of county and branch societies and to program chairmen upon request. As soon as the listings are complete, the material will be sent to the publishers, and the pamphlet prepared for distribution.

This committee makes it possible for county medical societies to develop and maintain a high standard of scientific presentation at county medical society meetings throughout the year. The committee has requested that the local society extend courtesy to the speaker, allow him to appear before the regular business session of the group, arrange to meet him and see that he has transportation to and from the meeting, and thank him officially for the preparatory work which he has done. The expenses of the speakers are paid by the local society whenever possible. If funds are not available, the state society assume the expenses of the speaker in order to furnish scientific speakers to those county medical societies sufficiently interested to plan and carry out good scientific meetings for their members.

Again, this is another service available to members through the payment of dues.

*Committee on Tuberculosis Control.* The Committee on Tuberculosis Control has made various recommendations to the Council and to the House of Delegates from time to time, to assist in the eradication of tuberculosis throughout the State. In the spring of 1953 letters were sent to all county society secretaries asking that a Committee on Tuberculosis be appointed at the

county level. These committees were asked to take an active interest in the tuberculosis control program in their local counties in order that the county society and the state society could take more effective action in the early recognition and eradication of tuberculosis.

The committee endorsed the survey method for the control of tuberculosis, and recommended follow-up 14 x 17 films by the survey agency in order that full value may be obtained in any such activity. The committee recommended routine chest x-rays for all admissions to hospitals in the state of Illinois. The committee recommended the endorsement of various legislative bills in the last session of the Illinois legislature, some of which ultimately were enacted into law. The chairman, Dr. George C. Turner, Chicago, was and continues to be, actively interested in this field of society activity which lends protection to the population of the state, and aids the physicians in the state in doing his professional best for the people under his care.

*Committee on Voluntary Prepayment Plans.* Following a stormy birth, a turbulent and controversial youth, this Committee on Voluntary Prepayment Plans for Medical and Surgical Care, developed and brought into being "The Illinois Plan." Under this plan six old line insurance companies are writing policies to cover groups interested in carrying medical and/or surgical insurance. Those carriers are:

1. The Aetna Casualty and Surety Company, 120 S. LaSalle St., Chicago
2. Illinois Mutual Casualty Company, Peoria
3. John Hancock Mutual Life Insurance Company, 209 South LaSalle St., Chicago
4. Northern Trust Life Insurance Company, Aurora
5. G. H. Poulsen and Company, 69 W. Washington St., Chicago, representing the Metropolitan Casualty Insurance Company.

Four Blue Shield Plans are in operation in Illinois:

1. Illinois Medical Service, Chicago
2. Medical Surgical Service of Illinois, Alton
3. Northern Illinois Medical Service, Rockford
4. Rock Island County Medical Service, Moline.

These plans all continue to grow. The Committee continues to supervise and work to im-

prove the coverage offered the residents of Illinois insured under any of these policies.

Blue Cross Hospitalization insurance is carried by more than 21½ million people in this state; while more than 7 million people in Illinois now carry some kind of hospital coverage. Through the work of this committee it seems likely that the rural population (perhaps through Health Improvement Associations) of virtually every county in Illinois will have access to both Blue Cross and Blue Shield through enrollment

facilities of some local group.

The chairman of the committee, Dr. Percy E. Hopkins, of Chicago, and the members of his committee, continue to supervise this work, check the coverage offered, help to extend the services, protect the members of the medical profession and the people of the state in every way possible, to provide the best medical and surgical insurance for all concerned, and to maintain the high standards in hospital coverage offered the residents of Illinois.

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## HOME CARE

The extraordinarily high cost of hospitalization has been recognized in numerous efforts of various sorts to transfer to the home the care of illnesses that do not actually require the elaborate provisions of a modern hospital. The best known of such projects, and one of the most successful, has been the Montefiore Plan in New York City. Everywhere, the presence of a well planned and well supervised public health nursing service plays an important role in home care. In all such programs, and in many other types of domestic emergency, there is a fundamental need to provide, not only for the care of the patient, but for the performance of the non-technical household tasks which a handicapped housekeeper is unable to perform.

In Denmark, a comprehensive national program has been initiated to meet this need.

During the first year of its operation, 23,000 families in Copenhagen alone have taken advantage of a law providing government subsidized household help during family emergencies at a cost scaled at the family's ability to pay. The household helpers, middle aged women, are government trained in the arts of housekeeping, cooking, repairing clothing, caring for children, and budgeting. Their stay with any one family generally is restricted to a fortnight. Illness in the home accounted for more than half of the answered calls for help, and both hospitals and clinics have been reporting a declining demand for hospital treatment since the law has been in operation. In cases where it has been necessary for wives to enter hospitals, the household helper has been able to preserve the home for the husband and children, and the authorities consider this the most important result of the law. *Editorial, Visiting Homemaker. Am. J. Pub. Health, Nov. 1953.*

# CORRESPONDENCE



## SECRETARIES MEET APRIL 4

The 1954 annual Illinois State Medical Society Secretaries' Conference will be held in the Hotel Leland, Springfield, April 4. It will be an all day session, beginning at 9:30 a.m., including luncheon as guests of the Illinois State Medical Society, and running until 4:00 p.m. Be sure that date is on your calendar.

This meeting will replace the annual Secretaries' Conference hitherto held during the annual meeting of the Illinois State Medical Society. All county society and branch society officers of the Chicago Medical Society and other interested members will be welcome.

The change reflects the multiplicity and importance of the issues now before organized medicine, and the importance of common action toward their solution. It seems important that more time be devoted to scrutiny and discussion of these issues for the purpose of arriving at firm decisions and a united program.

For that reason, the officers of the conference have determined to spend all day at the task, instead of confining it to a dinner meeting.

It is also believed that by moving the meeting to a downstate city, which is easily accessible, a larger attendance will be obtained.

Details of an interesting program, now being worked out by Dr. Maurice M. Hoeltgen, Chicago, secretary of the conference, and his advisors, are being sent to all secretaries of county medical

societies and branch societies. It is important that the reservation card enclosed with the mailing be returned as directed, in order that facilities for all attending may be available.

Please put this date on your calendar, and make all necessary arrangements to have every society and branch represented.

## AMERICAN GOITER ASSOCIATION

The 1954 Annual Meeting of the American Goiter Association will be held at the Somerset Hotel, Boston, Massachusetts, April 29, 30, May 1. The program for the three day meeting will consist of papers and discussions dealing with the physiology and diseases of the thyroid gland. For additional information, those interested may write to John C. McClintock, M.D., Corresponding and Recording Secretary, 149½ Washington Avenue, Albany, New York.

## GRATEFUL LADY TRYING TO LOCATE ILLINOIS PHYSICIAN

The Editor has received a letter from a lady in Corpus Christi, Texas, in which she was anxious to learn the name and address of an Illinois physician whom she stated rendered a fine service. She stated that she was a passenger on a Rock Island R.R. Rocket train which left Houston, Texas, the evening of January 9, 1950. She was going to Topeka, Kansas. On the train from Los Angeles to Houston, she was quite ill, but was determined to go on to

Topeka. After leaving Houston she became worse, and asked the conductor to see if there was a doctor on the train. The conductor found an Illinois physician who was returning to his home from California. After his examination, the physician insisted that the lady must leave the train at the next stop, and go to a hospital for necessary care. She wanted to go to Dallas, then take a plane to Topeka but this proposal was not approved by the physician. She was removed from the train and taken to a hospital where she stated, she was told that her condition was an emergent one. Later she went to Topeka, and was taken to another hospital, where she remained for three months. She has been slowly recovering from what she states is a malignant condition, and she is desirous of learning the name of the Illinois physician who befriended her. She is anxious to express her gratitude to him, and wrote to the Director of the Illinois Department of Public Health to see if he could aid her in locating this Illinois physician. Dr. Cross informed the lady that he was referring her request to the Editor in the hope that he could publicize it in the Illinois Medical Journal. If the physician in question will write to the Editor, we will give him more information relative to the lady in Texas, and will also write to her promptly.

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### **ARMY SCHEDULES THREE-YEAR RESIDENCY IN ANESTHESIOLOGY**

The Army Medical Service residency program in anesthesiology will be increased in term to three years beginning July 1 to give candidates additional training, it has been announced by Major General George E. Armstrong, Surgeon General.

The new plan announced by the Surgeon General provides for the two years of clinical training required for American Board of Anesthesiology certification and an additional year devoted to research and development training coordinated with the basic sciences in anesthesiology.

According to the new plan, selected Medical Corps officers will spend their first year of the three-year residency at Walter Reed Army Medical Center, Washington, D. C., where they will receive fundamental clinical training.

The second year will be presented at the Army Medical Service Graduate School, Walter Reed

Army Medical Center, Washington, and will be devoted to research and development.

The last year of residency under the new program will be spent at one of four Army hospitals and will present the candidates with a summation of training with clinical and teaching experience. The four hospitals to be utilized in the program are: Brooke Army Hospital, Brooke Army Medical Center, Fort Sam Houston, Texas; Fitzsimons Army Hospital, Denver, Colorado; Letterman Army Hospital, San Francisco, California; and Walter Reed Army Hospital, Walter Reed Army Medical Center, Washington, D. C.

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### **DOCTOR DRAFT REGISTRANTS MAY BE RE-ASSIGNED TO ARMY READY RESERVE UNITS**

Reserve physicians and dentists who are not currently under orders for active military duty may join the Ready Reserve Units of the Army Medical Service according to an announcement today by Maj. Gen. George E. Armstrong, Army Surgeon General.

This will be accomplished by permitting the special registrants under the Doctor Draft Act and others who are in a USAR Control Group to be transferred immediately to fill an authorized vacancy in a Ready Reserve Unit. Formerly, such a re-assignment was prohibited prior to the completion of a tour of extended active duty.

Although transferred, the officer will still be subject to an order to active duty without his consent as an individual classified under the Doctor Draft and will be subject too, to an order to active duty as a member of the unit.

The transfer however, is entirely voluntary and will be made only if the physician or dentist so desires.

An estimate of the possible numbers available for such re-assignment totals more than 900 Medical Corps officers and 183 Dental Corps officers.

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### **AMERICAN COLLEGE OF PHYSICIANS**

The thirty-fifth annual session of The American College Of Physicians will meet in Chicago, April 5-9, 1954.

*General Headquarters, Meetings and Registration* — Conrad Hilton Hotel.

*Technical Exhibit* — Exhibition Hall, Conrad

Hilton Hotel. 133 booths. Exhibitors limited to those on Invitation List. Exhibits restricted to products relevant to the practice of Internal Medicine or its allied specialties. Preference given to exhibits of a scientific nature, such as pharmaceuticals, equipment and medical books. All exhibits must be approved by the Committee on Exhibits.

*Meetings* — all to be held at Conrad Hilton Hotel.

*Program* — will appear in the February, 1954, issue of this journal, and will be printed separately and distributed to all members of the American College of Physicians and non-member physicians whose names are on the mailing list. Program will consist of General Scientific Sessions, Symposia, Color Television Clinics, Panel Discussions and Clinical-Pathological Conferences. Speakers and participants will be carefully selected authorities in the several fields of Internal Medicine and allied specialties, including Pediatrics, Dermatology, etc.

*Admission of Non-members* — Qualified physicians may attend this Session as visitors, if sponsored in advance by letter or in person by a member of the College; such physicians shall pay a registration fee of \$25.00 and shall be entitled to one year's subscription to the Annals of Internal Medicine (in which the proceedings will be published) included within such fee. bona fide hospital resident, regardless of their location in North America, may be admitted without fee, upon presentation of proper credentials from their hospitals. Members of the Medical Corps of the Army, Navy, Public Health Service, Air Force and Veterans Administration, either of the United States or Canada, may also be admitted free, upon presentation of proper credentials.

*Entertainment* — An extensive and attractive program is being arranged for physicians and their ladies, including a concert by the famous Chicago Symphony Orchestra.

Leroy H. Sloan, M. D., President, Chicago, Illinois; Howard Wakefield, M. D., General Chairman, Chicago, Illinois; Edward R. Loveland, Executive Secretary, 4200 Pine St., Philadelphia 4, Penn.

## POSTDOCTORAL FELLOWSHIPS

The National Foundation for Infantile Paralysis announces the availability of a limited number of postdoctoral fellowships in the field of public health and preventive medicine. The purpose of these National Foundation fellowships is to prepare physicians to fill the many vacancies existing in public health and preventive medicine, with priority to those who are interested in entering the teaching field.

The fellowships are for one or more years at an approved school of public health, with a period of field experience when arranged by the school. Stipends to Fellows are based on the individual need of each applicant. Fellowships may cover tuition, maintenance and an allowance for books, if required. Appropriations of \$320,600 in March of Dimes funds have been made to cover the cost of the program.

Eligibility requirements include United States citizenship, sound health, graduation from an approved school of medicine and completion of at least a one-year internship in an approved hospital. Selection of candidates will be made on a competitive basis by a Clinical Fellowship Committee composed of leaders in the fields of medicine and professional education.

Complete information concerning qualifications and applications may be obtained from the Division of Professional Education, National Foundation for Infantile Paralysis, 120 Broadway, New York 5, N. Y.

## CHEST DISEASE SYMPOSIUM FOR GP'S IN SARANAC LAKE THIS SUMMER

The third annual Symposium on Tuberculosis and Other Chronic Pulmonary Diseases for General Practitioners will be held in Saranac Lake, New York from July 12 through 16, 1954. It is approved by the American Academy of General Practice for 26 hours of formal credit for its members.

The Symposium is sponsored by the American Trudeau Society, the Saranac Lake Medical Society and the Adirondack Counties Chapter of the New York State Academy of General Practice. The registration fee is \$40 for A.A.G.P. members and \$50 for non-members.

The scope of this year's Symposium has been broadened to cover chest diseases other than

tuberculosis. Included in the course will be discussions of the diagnosis and treatment of nontuberculous pneumonias, pulmonary cancer, lung abscess, fungus diseases, bronchiectasis, sarcoid, cystic disease, emphysema, and the pneumoconioses.

The speakers and panel members at the Symposium will include thirty-four physicians, surgeons, and scientists from Saranac Lake and surrounding areas. Guest lecturers include Dr. D. Ewan Cameron, Professor of Psychiatry, McGill University, Montreal, and Dr. Donald Miller, Assistant Professor of Thoracic Surgery, University of Vermont Medical School, Burlington, Vermont.

These Symposia are the result of many requests, during the last few years, from the General Practitioners for a postgraduate course on chronic pulmonary diseases designed for them and presented over a period short enough so that they might readily attend. The 1954 Symposium has been planned to meet those needs and to cover all important aspects of these diseases from the General Practitioner's point of view.

Many of the sessions are informal panel discussions with ample opportunities for questions from the audience.

Complete information concerning this program can be obtained by writing: Richard P. Bellaire, M. D., Chest Disease Symposium, P. O. Box 2, Saranac Lake, New York.

## **PAN-PACIFIC SURGICAL ASSOCIATION CONGRESS**

Doctors are cordially invited to attend the Sixth Congress of the Pan-Pacific Surgical Association to be held in Honolulu, October 7-8, 1954, and are urged to make arrangements as soon as possible if they wish to be assured of adequate facilities.

An outstanding scientific program with over 100 leading surgeons, including sessions in all divisions of surgery and related fields, promises to be of interest to all members of the profession. An extensive social program is being developed for the doctors' families.

The Association office has been appointed as travel agent for those attending the Congress and it is important that all hotel and travel reservations be made through the Honolulu headquarters of the Pan-Pacific Surgical Association.

For further information, please write to F. J.

Pinkerton, M. D., Director General, Pan-Pacific Surgical Association, Suite Seven, Young Building, Honolulu, Hawaii.

## **THIRTEEN MEDICAL MEETINGS TO VIEW COLOR TV IN 1954**

Thirteen medical meetings in 1954 will present color television as part of their respective postgraduate teaching programs. Smith, Kline & French Laboratories, the Philadelphia pharmaceutical firm that sponsors and produces all color telecasting at medical assemblies, has released the 1954 schedule of meetings which will view televised operations and clinics.

This year, the medium will literally be seen in the four corners of the United States, making an appearance in New York, Los Angeles, Miami and Vancouver, B. C. Since June 1949, when SKF presented the first program of any kind ever to be televised in color, more than 272,000 doctor-visits have been paid to SKF programs at 51 medical meetings in this country, Montreal and Paris. During this time, 454 operations and 675 clinical presentations have been televised.

The schedule is as follows:

March 2-5, Chicago Medical Society, Chicago  
March 10-12, Michigan Clinical Institute, Detroit  
April 5-9, American College of Physicians, Chicago  
May 10-13, California Medical Association, Los Angeles  
June 14-16, Canadian Medical Association, Vancouver  
June 21-25, American Medical Association, San Francisco  
September 14-19, Internat'l College of Ophthalmology, New York  
September 19-25, American Academy of Ophthalmology & Otolaryngology, New York  
October 5-7, Kansas City Southwest Clinical Society, Kansas City, Mo.  
November 14-19, American College of Surgeons, Atlantic City  
Nov. 30-Dec. 3, American Medical Association, Miami

## **REGIONAL MEETING OF THE NATIONAL GASTROENTEROLOGICAL ASSOCIATION**

A regional meeting of the Central Region of the National Gastroenterological Association will be held in Milwaukee, Wisc., Sunday afternoon, 28 March 1954. The scientific sessions will be held at the Hotel Schroeder at 2:00 P.M., following the semi-annual meeting of the Association's National Council.

The Central Region is comprised of the states of Illinois, Indiana, Iowa, Kansas, Michigan,

Minnesota, Missouri, Nebraska, North Dakota, Ohio, South Dakota and Wisconsin.

Members of the medical profession are cordially invited to attend. A copy of the program may be obtained by writing to Dr. Joseph Shai-ken, 536 West Wisconsin Ave., Milwaukee 3, Wisc., or to the Secretary, National Gastroenterological Association, 33 West 60th Street, New York 23, N. Y.

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## **CHICAGO MEDICAL SOCIETY SPECIAL AIR TRANSPORTATION TO AMA CONVENTION AND TOUR OF HAWAIIAN ISLANDS**

Plans are well advanced for special privately chartered air transportation to the AMA convention at San Francisco and an all-expense tour of the Hawaiian Islands following, including air transportation, ground transportation and hotels in the Islands.

The tentative schedule calls for take-off at Midway Airport, Chicago, on United Air Lines DC6, Sunday, June 20, 1954, arriving at San Francisco the same day. At the conclusion of the convention on June 25 take-off for Honolulu is scheduled for midnight from Municipal Airport, South San Francisco, arrival at Honolulu about 8 A.M., June 26. The next eight days will be spent in touring Oahu, Maui and Hawaii by air and limousine with overnight stops on the various islands. In Honolulu our hotels are at Waikiki Beach where you may have choice of hotels and ample time to enjoy the beach.

Take-off for California is scheduled for following day with return to Chicago immediately — with passenger comfort in mind. This plan permits the widest possible excursion consistent with care-free and comfortable transportation — and return to duty at the earliest possible time. Much planning and arranging remains to be accomplished. It is highly necessary that we know as early as possible the numbers interested in this plan. We are endeavoring to cut costs down to a point that cannot be equaled by any other plan of transportation — private or commercial. This is not a commercial plan for profit. No "travel agencies" are directing this plan. It is being engineered by members of the Chicago Medical Society for members of this and associated societies, their families, friends and guests.

The costs involved will depend upon the number of passengers taking the trip. The more passengers — the less cost. In order to arrive at precise costs and itineraries it will be necessary to know the approximate numbers involved in the journey. To that extent we urge — if this plan is of interest to you — to immediately write the undersigned indicating the probable number in your immediate party. Your expression of interest will not be considered a commitment. You can well understand that reservation of equipment, hotel rooms, limousines and the like must be accomplished well in advance. With that in mind we would appreciate your expression of interest at the earliest possible moment.

Write — Elmer V. McCarthy, M. D., Chairman, Transportation Committee, Chicago Medical Society, 86 E. Randolph Street, Chicago, 1 Illinois.

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## **JOINT MEETINGS**

The North Side Branch of the Chicago Medical Society and the Chicago Heart Association will meet on Thursday, April 1, 1954 at the Drake Hotel.

### **SCIENTIFIC PROGRAM 8:00 P.M.**

"The Treatment of Thrombo-embolic Disease"

..... Dr. Ovid O. Meyer  
Professor of Medicine and Chairman, Department of Medicine, University of Wisconsin Medical School, Madison, Wisconsin

DISCUSSION: Dr. Wright Adams, Professor and Chairman, Department of Medicine, University of Chicago

Dr. Geza deTakata, Clinical Professor of Surgery, University of Illinois College of Medicine; Senior Attending Surgeon, St. Luke's Hospital

FELLOWSHIP GATHERING — 5:30 p.m.

DINNER — 6:30 p.m.

Reservations — CENTRAL 6-7764

William A Hutchison, President, North Side Branch; Ceasar Portes, Secretary-Treasurer, North Side Branch; Willard O. Thompson, Chairman, Program Committee, North Side Branch; Walter S. Priest, Chairman, Scientific Section, Chicago Heart Association; George A. Hellmuth, Chairman, Postgraduate Subcommittee, Scientific Section, Chicago Heart Association.

# NEWS OF THE STATE



## ADAMS

**Society Chooses New Officers.**—Dr. Theodore L. Stebbins is the new president-elect of the Adams County Medical Society. Carl F. H. Pfeiffer is president. Other officers are Dr. Ernst A. Griep, 1st vice president; Dr. E. Hayden Keys, Jr., 2nd vice president; Dr. Newton DuPuy, secretary; Dr. Harold Swanberg, treasurer; Dr. Walter M. Libmann, accounting officer; Dr. J. Frederick Ross, medico-legal adviser; Dr. Carl W. Hagler, historian; Dr. Hilliard M. Shair, editor; Dr. Robert C. Murphy, Councilor (3 years) and Dr. Roger G. Clarke, censor (3 years).

## COOK

**Wesley Plans Expansion.**—Announcement has been made of a plan to unify the Wesley Memorial Hospital, 250 East Superior Street, and the Chicago Memorial Hospital, 660 East Groveland Park. Construction plans of a new five-story building just north of the present Wesley Memorial Hospital were also announced. The tentative effective date of the proposed merger is July 1, according to newspaper reports. The combined institutions will be known as the Chicago Wesley Memorial Hospital. Plans to convert the present Chicago Memorial Hospital, which has a 100 bed capacity, into a convalescent home, is now under consideration. The proposed merger will, it is believed, provide more and better service for the patients as a result of the enlarged medical staff in addition to expanded physical facilities. The new building would provide 117 beds in addition to Wesley's present capacity of 617 beds. Another gainful objective would be that, in cooperation with the Northwestern University Medical School, educational opportunities will be

expanded for medical students, students in the various adjuncts of medicine, and the medical and nursing professions. In addition it is believed that the merger will advance medical knowledge through more extended study and research in cooperation with Northwestern Medical School.

**Rubin Fellowship Established.**—The Rubin Brothers Foundation Research Fellowship will be established with a fund of \$14,000 given to the Chicago Medical School recently. Donors of the fund are Morris J. Rubin, founder and president; Roy Rubin, vice president; and Irving Rubin, secretary and treasurer, of the Ralston Steel Corporation.

**Medical Exhibits of Interest.**—An elaborate exhibit, prepared by Drs. George Eisenberg and Louis D. Minsk on babies' feeding bottles and medicinal spoons, was recently displayed at the John Crerar Library. The exhibit dates from 400 A.D. to the present time. On display at the University of Illinois College of Medicine recently was an exhibit of ancient trepanned skulls and early American instruments in trepannation.

**Physician Wills Half Estate to Hospital.**—Dr. George G. O'Brien, who died October 3, 1952, age 77, left \$379,784 of his \$620,994 gross estate to Mercy Hospital. While there were a number of specific bequests to relatives, the amount to Mercy Hospital represented the residue of Dr. O'Brien's estate.

**Dr. Davis Named Chief of Staff.**—Dr. M. Edward Davis, a member of the University of Chicago Lying-in Hospital medical staff for the past 29 years, has been named chief of staff. He succeeds Dr. William J. Dieckmann, chairman of the department of obstetrics and gynecology. Dr. Dieckmann resigned his administrative post, which he has held for 12 years, to devote full time to clinical activities and research as the Mary Campau Ryerson professor of obstetrics and gynecology.

Dr. Davis, who was named the Joseph Bolivar DeLee professor of obstetrics in 1947, began his obstetric career under the late Dr. DeLee, who founded the Chicago Lying-in Hospital. Since the founding of the hospital 59 years ago, it has been headed by only three administrators, DeLee, Dr. Fred L. Adair, now emeritus, and Dieckmann.

Dr. Davis, recipient of the gold medal of the American Medical Association, was honored with Dr. Adair and Morris S. Kharasch, University of Chicago chemist, in 1935, for isolation and the successful application of ergonovine in childbirth. He also received the annual award of Central Association of Obstetricians and Gynecologists in 1937 for his work on the production of artificial ovulation.

Dr. Dieckmann, also internationally known for his research on toxemias of pregnancy and nutrition for obstetric patients, became chairman of the department in 1942 and a member of the staff in 1931.

**Grants-In-Aid.**—New grants for research totalling nearly \$40,000, have been received recently by the Chicago Medical School, as announced by President John J. Sheinin.

To Dr. Piero P. Foa goes \$23,652 from the National Institute of Arthritis and Metabolic Diseases of the U.S. Public Health Service over a 3-year period for studies in experimental diabetes entitled "Aspects of Pancreatic Physiology." Dr. Foa has also received \$1,000 from Simon L. Solomon of Detroit, Michigan for further work in experimental diabetes. Dr. A. Robert Goldfarb has received \$8,000 from the National Science Foundation, Washington, D.C. for studies on the structure and reactions of proteins; and \$1,000 from R. B. Smith, an allergist of Akron, Ohio, for studies on the isolation of the active principle of ragweed pollen. Dr. Ben B. Blivaiss received \$5,500 from the National Cancer Institute of the U.S. Public Health Service for "Study of the Mechanism of Induction of Testicular Tumors." The Smart Family Foundation of Chicago has given \$500 to the Division of Cardiology for phonocardiographic studies of patients with congenital heart disease, to be done under the direction of Dr. Aldo A. Luisada.

**Winners in Essay Program.**—First prize of \$50 in the second annual prize essay program of the Chicago Urological Society went to Dr. Carl D. Berry, Jr., Veterans Administration, Hines. Title of the winning essay is "Comparison of the Urethral Meatus in Circumcised and Uncircumcised Adult Males." Second prize of \$25 went to Dr. Raymond Firfer, Cook County Hospital, for his work on "Bilateral Adrenalectomy Follow-Up. A Case Report." Judges for this second award made available to urologic residents in the Chicago hospitals were Drs. James W. Merricks, Don E. Murray, and J. Lester Wilkey.

**Edward Ochsner Observes Eighty-Sixth Birthday.**—Dr. Edward H. Ochsner, who has held numerous

offices in the Chicago Medical Society, observed his eighty-sixth birthday January 12.

**Chest and X-ray Physicians Hold Joint Meeting.**—The Illinois Chapter of the American College of Chest Physicians held a joint meeting with the Chicago Roentgen Society at the Sheraton Hotel, Chicago, February 11. Dr. Leo G. Rigler, professor and chief of the department of radiology, University of Minnesota School of Medicine, Minneapolis, was the principal speaker. His subject was "The Roentgenologic Aspects of Diseases of the Pulmonary Vessels."

**College of Surgeons Wins Zoning Appeal.**—The city zoning board recently approved the appeal of the International College of Surgeons from the building commissioner's refusal to permit conversion of its building at 1516 North Lake Shore Drive into a surgeons' hall of fame museum, the Chicago Tribune reported January 17. In a hearing, Dr. Max Thorek, general secretary of the college, reportedly told the board that the group is an organization of surgeons whose function is the exchange of ideas for research and practical purposes. The hall of fame will consist of murals, manuscripts and rooms dedicated to different countries, commemorating their individual surgeons of renown. Dr. Thorek held the intended use of the four story headquarters of the college, located in an apartment house zone, was legal on the ground it was educational.

**Society News.**—The Illinois Psychiatric Society was addressed, January 20, by Dr. Rudolph G. Novick, medical director of the Illinois Society for Mental Health, on "General Proposals for Forthcoming Programs." Dr. Groves B. Smith, medical director, Beverly Farm Home and School, Godfrey, discussed the "Children's Program," Dr. F. Garm Norbury, medical director, Norbury Sanatorium, Jacksonville, the "Adult's Program", and Louis B. Shapiro, member of the staff of the Chicago Institute for Psychoanalysis, Chicago, the "Research and Training Program."

**Illinois Chooses New Dean.**—Dr. Granville A. Bennett was appointed dean of the University of Illinois College of Medicine by the Board of Trustees at its meeting here, January 19. Dr. Bennett currently has served as professor of pathology and head of the department at the University's College of Medicine. He also has been pathologist-in-chief of the Research and Educational Hospitals. Dr. Bennett plans to assume the deanship sometime this spring, the exact date to be announced later. He will succeed Dr. Roger A. Harvey, who has served as acting dean since January 1, 1953. Dr. Harvey will return to his full-time position as professor of radiology and head of the department in the College of Medicine and radiologist-in-chief of the Research and Educational Hospitals. Dr. Bennett has been head of the department of pathology at the University since 1944. Prior to this, he was head of the department of pathology and bacteriology at Tulane University School of Medicine, New Or-

leans. He once taught at Harvard Medical School, starting with the rank of instructor and attaining the rank of associate professor. Dr. Bennett is a past president of the Chicago Pathological Society, the Illinois Society of Pathologists, the American Association of Medical Museums and the New England Pathological Society.

**Personal.**—Dr. Maurice H. Cottle, professor of otolaryngology, Chicago Medical School, conducted a clinic in nasal and septum surgery at Yale University School of Medicine, January 23. Dr. George Fischer, Wilmette, will assist Dr. Cottle in this project.

**Edward Lorenzo Holmes Award.**—The Institute of Medicine of Chicago has established by the Edward Lorenzo Holmes Award and Memorial Lecture under the provisions of the trust fund established by the late Rudolph Holmes, a Fellow of the Institute of Medicine from 1915 to 1931. The trust fund creates the "Rudolph Wieser Holmes and Maria Baxter Holmes Fund" as a memorial to Dr. Edward Lorenzo Holmes, father of Rudolph Holmes. Edward Lorenzo Holmes was a pioneer Chicago ophthalmologist, 1828-1900. According to the proceedings of the Institute of Medicine, the income from this fund is to be used for prizes and awards for distinguished contributions to medical science. Dr. Rudolph Holmes directed that recipients of such prizes and awards should be selected by the Board of Governors of the Institute and that preference be given to contributions in ophthalmology, especially those made by investigators under thirty-five years of age. Arnall Patz, Baltimore, has been selected as the first recipient because of his experimental work on several species of animals reproducing the clinical and histological picture of retrolental fibroplasia by means of high concentration of oxygen. Dr. Patz' experiments provide the first lead to the elucidation of the etiology of this condition in premature infants. The award was presented to Dr. Patz at a meeting of the Institute and the Chicago Ophthalmological Society, March 1.

**Hektoen Commemorative Services.**—The Second Ludwig Hektoen Commemorative Services were held March 14, in the Hyde Park Baptist Church, Chicago. The Chicago Pathological Society sponsored the ceremony in respect to the memory of the late famous pathologist, Dr. Hektoen. Portions of Mozart's Requiem were sung by the choir with Maude Nosler as soloist and assisted by members of the Chicago Symphony Orchestra.

**Memorial Meeting to Louis S. Robins.**—The Chicago Pediatric Society in joint session with the Chicago Medical Society held a session at the Children's Memorial Hospital, February 16, designated as the "Dr. Louis S. Robins Memorial Meeting." Dr. Sidney Levinson spoke on "Has Early Years"; Drs. William and Otto Saphir, "His Illness", and Dr. Lee McKendree Eaton, professor of neuro-psychiatry, Mayo Foundation, spoke on "Myasthenia Gra-

vis." Dr. Robins graduated at Northwestern University Medical School in 1926. He had been certified by the American Board of Pediatrics, was a member of the American Academy of Pediatrics and the American College of Allergists. He had been affiliated for many years with Sarah Morris Hospital Children and Michael Reese Hospital. He died at the age of 55 in January, 1953.

**Pilot Study on Nursing.**—A pilot study in team nursing, a method which focuses attention on the social and psychological aspects of nursing of the patient in addition to physical care, is being conducted on a 50-bed medical ward at the University of Illinois Research and Educational Hospitals. This experimental plan in nursing is being sponsored jointly by the Department of Nursing under Director Ann L. Laird and the School of Nursing under Acting Director Miss Emily C. Cardew. Miss Frances M. Hoefling, nursing supervisor, and Miss Catherine Kolitsch, head nurse, are directing the plan on the floor. The new program provides for care of the patients by floor nursing teams composed of graduate nurses, practical nurses, and nurses aides. The head nurse of the floor, who acts as coordinator for the groups, assigns patients and nursing personnel to each team. Plans for the care of the patients are formulated in daily conferences called by the graduate nurse appointed as leader of the team. At the conference regular nursing duties are assigned to each member of the group. Team members are urged to review the nursing care of each patient. Emphasis is placed upon considering the mental attitude of the patient while administering nursing care. Miss Grace Calmer, assistant to the Director of Nursing, and Miss Katherine Sehl, assistant professor of nursing, who have planned and supervised the program, point out that the team method provides for more intensified individual care of the patient, and also promotes better coordination between nurses and aides on the floor. They emphasize that it is more democratic than older methods because each person on a team may contribute to the formulation of a care plan. And each can be used according to her own ability. Another favorable aspect of the program is that every patient has direct supervision of his care by one professional nurse. Five teams now are being employed in the experiment. If the new program proves satisfactory, it may be extended to other nursing units in the hospital. Eventually this medical ward nursing unit may be used as a training center for nurses from other services. Team nursing is a recent development in the field of nursing. Since World War II, the shortage of nurses has brought about the increased use of practical nurses and aides for the care of patients. Sponsors of the team plan feel that the new method provides for better utilization of these personnel.

#### DE KALB

**New Officers.**—Dr. E. B. Glenn, DeKalb, was elected president of the DeKalb County Medical

Society at a recent meeting. Dr. Grant Suttie, De Kalb, was elected vice president and president elect. Other officers are Dr. C. E. Clark, Sycamore; secretary and treasurer; Dr. J. C. Ellis, DeKalb, delegate to the Illinois State Medical Society; Dr. C. E. Clark, Sycamore, alternate delegate; Drs. J. F. Eggers and H. J. Trapp, both of Sycamore, and D. J. Ladd, DeKalb, censors; members elected to the grievance committee are: Drs. H. G. Dakin, Sandwich; C. E. Clark, Sycamore; D. J. Ladd, DeKalb; Emery Fenwick, Sycamore; J. W. Ovitz, Sr., Sycamore; E. W. Telford, DeKalb.

### KANKAKEE

**Personal.**—Dr. Alfred P. Bay has resigned as superintendent of the Manteno State Hospital to accept a position in the same capacity at the state hospital in Topeka, Kansas.

### KNOX

**Society News.**—A grievance committee has been appointed by the Knox County Medical Society to give full hearing to every complaint concerning medical fees and subsequently to take appropriate action. Dr. Charles Krause, Chicago, addressed the society recently on "The Rh Factor in Obstetrics." A guest of the society at the meeting was Dr. F. L. McDaniel of the American Psychiatric Association who is making a survey of mental hospitals. At the time of the meeting, Dr. McDaniel was inspecting the Galesburg State Research Hospital.

### LAKE

**New Officers.**—Dr. Gerrit Dangremond, Lake Bluff and Waukegan was elected president of the Lake County Medical Society at its recent annual meeting. Other officers are Dr. Bradford J. Willett, Fox Lake, vice president; Dr. Lawrence R. Qualmann, Grayslake, secretary; Dr. William Barnes, Waukegan, treasurer; Dr. Donald Nellins, Waukegan, board of censors for three years; Dr. Asa Meyers, Waukegan, representative to the Victory Memorial Hospital Board; Dr. George B. Callahan, Waukegan, delegate to the Illinois State Medical Society; Dr. Frank Carter, Waukegan, alternate delegate, two year term; Drs. John J. Milroy, chairman, Edward E. DeLong, John E. Freeland and Walter J. Reedy, grievance committee.

### MACON

**New Officers.**—Dr. F. Glenn Irwin was installed as president of the Macon County Medical Society at a recent meeting. Dr. Maurice D. Murfin was named president-elect; Dr. Edmund S. Lockhart, secretary, and Dr. Welland A. Hause, treasurer.

### RANDOLPH

**Society News.**—The "Glacken Law" was discussed by Dr. Clifton Hall, deputy director of the division of tuberculosis control, Illinois State Department of Public Health, at a meeting of the Randolph County

Medical Society at St. Clement's Hospital in Red Bud, January 21. The following were guests of the society at the meetings: George White, Chester; Theodore Rohlfing, Red Bud, and Robert Barber, Sparta, all county commissioners; A. C. Scott, M.D., Evansville; Russel Orr, Ph.G., Steeleville, and A. G. Guker, Ph.G., Red Bud, all members of the county sanitation board; Miss Emily Gibson, Sparta, and Mrs. Rene Patterson, DuQuoin.

### ROCK ISLAND

**Society News.**—Dr. E. A. Edwards, Chicago, addressed the Rock Island County Medical Society at St. Anthony's Hospital Auditorium, Rock Island, January 12, on "Gynecological Problems."

### SANGAMON

**Hospital Election.**—Dr. William W. Curtis was elected president of the attending staff of Memorial Hospital, Springfield, at its business meeting January 5. Other officers are: Drs. Harvard L. Romence, vice president; H. B. Henkel, Jr., secretary; George G. Stericker, Thomas D. Masters and Frank M. Davis, members of the executive committee.

**Society News.**—The Sangamon County Medical Society was addressed at its meeting in Springfield, February 4, by Drs. Floyd Barringer on "The Examination of the Cranial Nerves"; Ray Pearson, "Clinical Ballistocardiography" and H. B. Henkel, Jr., "The Significance of Hematuria."

### VERMILION

**Society Chooses New Officers.**—Dr. R. E. Bucher was installed as president of Vermilion County Medical Society at its recent meeting in Danville. Other officers are Drs. E. M. Dewhirst, vice president; L. W. Tanner, secretary-treasurer; Jean Moore, delegate to the Illinois State Medical Society; Arthur Brandenberger, alternate delegate. Dr. Harlan English as Councilor of the Eighth District of the Illinois State Medical Society. The society was addressed, February 2, by Dr. John Lindsay, professor of otolaryngology, University of Chicago School of Medicine on "Vertigo".

### GENERAL

**Society News.**—The American Academy of Forensic Sciences held their annual meeting at the Drake Hotel, February 25-27. On Friday morning there were section meetings on forensic pathology, toxicology, psychiatry, immunology, law and police science. The general discussion in the forensic sciences was held in the Walton Room. Mr. Stanley Barnes, assistant attorney general of the United States, was the principal speaker at the banquet on Friday night. The medical profession and allied branches were invited to attend the meetings and the banquet.

**Postgraduate Education.**—The Chicago Heart Association cooperated with three branches of the

Chicago Medical Society in presenting postgraduate programs in February. For the Jackson Park Branch, the theme was "The Use of Anticoagulant Drugs". Speakers were Drs. Emmet B. Bay, Norman B. Roberg, and George F. O'Brien. "Acute Coronary Disease" was the theme for the West Side Branch and speakers were Drs. Lyle A. Baker, William B. Wartman, and Gilbert A. Marquardt. The theme of the meeting of the scientific section of the Chicago Heart Association was "Long Term Results of Cardiac Surgery." Speakers were Drs. James A. Campbell, Willis J. Potts, Stanley Gibson, William E. Adams, Ormand C. Julian, and Ford K. Hick.

**Fluoridation Progress.**—More than 206,000 residents of 24 Illinois communities are now drinking fluoridated water, according to the Illinois State Department of Public Health.

This figure will be increased by 148,000 when fluoridation begins in nine other communities which now have state approval. Fluoridation of public water supplies to help prevent tooth decay among children has been advocated by the state health department and the Illinois State Dental Society since early 1951. Evanston with a population of 73,641, largest city in the state now fluoridating its water, and a part of Skokie embracing a population of 7,416 were in 1947 the first to adopt fluoridation. Second largest is Waukegan, with a population of 38,946. Ten of the 24 communities began fluoridation last year.

Three major cities are among the nine which have state approval but which have not yet begun fluoridating. They are: Joliet, 51,601; Quincy, 41,450, which is scheduled to start operation this month; and Moline, 37,397. The other six are Morton Grove, Newton, Geneseo, Chillicothe, Sparta and York Center. Others now fluoridating are: Carbondale, DeSoto, Carlyle, Beckemeyer, Winnetka, Northfield, LeRoy, Chester, Casey, Orion, Kenilworth, Park Forest, Lansing (supplied by Hammond, Ind.), Pleasant Hill, Assumption, Lawrenceville, Sumner, Bridgeport, Normal, Illinois Soldiers' & Sailors' Children's School at Normal and Dixon State School at Dixon.

**Conferences on Rheumatic Fever and Heart Disease.**—La Rabida Sanitarium, Chicago, announces that two, three day conferences on rheumatic fever and heart disease will be held on March 31 and October 9, 1954. These two periods will be provided in conjunction with the Committee on Rheumatic Fever and Cardiac Disease of the American Academy of Pediatrics for pediatricians and general practitioner or family physician. It will be conducted for three days by members of the hospital staff, together with others selected from the medical schools in the city with which the hospital is affiliated, and by invited guests.

The conference in March precedes the annual meeting of the American Heart Association in Chicago, to which those attending the conference will

be invited and to the areal meeting of the Academy in Los Angeles beginning the following Monday April 5th. The conference in October follows the annual meeting of the Academy of Pediatrics in Chicago, beginning on the last day of the Academy meeting. Pediatricians other than the Academy members are invited to attend the conference. Arrangements will be made also for anyone or a group attending a conference to devote a longer time to continued supervised instruction in rheumatic fever and the work of the hospital. Advanced registration will be required for those who wish to attend. Further information including tuition charge will be supplied on application to: CONFERENCE ON RHEUMATIC FEVER AND HEART DISEASE, LA RABIDA SANITARIUM, CHICAGO 49, ILLINOIS.

**"Your Doctor Speaks" over FM Station WFJL.**—Since the last issue of the Illinois Medical Journal, the following physicians have appeared in transcribed broadcasts in a series "Your Doctor Speaks" over FM Station WFJL:

**Frederick Stenn**, lecturer in history, University of Illinois College of Medicine, January 21, on "Discovering Lost Gems in Medicine."

**Wayne W. Fox**, Evanston, associate in medicine, Northwestern University Medical School, January 28, on "Immunization in Present Day Medicine."

**Elmer W. Hagens**, attending otolaryngologist, Wesley Memorial Hospital, February 4, on "What Do We Mean by Sinus?"

**Morris A. Kaplan**, assistant professor of medicine, allergy division, Chicago Medical School, February 11, on "Do You Recognize Your Allergies?"

**Lectures Arranged Through the Educational Committee of the Illinois State Medical Society:**

**Sanford A. Franzblau**, Maine Adult Evening School of the Maine Township High School, Des Plaines or Park Ridge, February 4, on Adding Life to Years.

**Preston V. Dilts**, Springfield, Rotary Club of Hillsboro, February 8, on Obesity.

**Marvin P. Padorr**, Biology Club of the Niles Township High School, Skokie, February 9, on Poliomyelitis.

**Abraham Aronson**, Kankakee, Will-Grundy Medical Auxiliary, Joliet, February 9, on Mental Hygiene.

**J. Charles McMillan, Jr.**, Oak Park, Maine Adult Evening School of the Maine Township High School, Des Plaines or Park Ridge, February 11, on Protecting Your Heart.

**Bernard Skorodin**, South Central Kiwanis Club, February 16, on Personality from the Psychiatric Viewpoint.

**Harry Slobodin**, Elmwood Park, Maine Adult Evening School of the Main Township High School, Des Plaines or Park Ridge, February 18, on Cancer.

**Earle E. Wilson**, Oak Park, Maine Adult Evening School of the Maine Township High School, Des Plaines, or Park Ridge, February 25, on A Concept of Personality and its Dynamics.

**Armand J. Mauzey**, Elmhurst, Maine Adult Evening School of the Maine Township High School, Des Plaines or Park Ridge, March 4, on The Menopause.

**David Slight**, Woman's Society of the First Methodist Church, Palatine, March 10, on The Effect of Alcohol on the Person Morally and Physically.

**Willard O. Thompson**, Maine Adult Evening School of the Maine Township High School, Des Plaines or Park Ridge, March 11, on The Male Climacteric.

**Richard Plunkett**, Chicago Area Associate Alliance, April 1, on International Aspects of Mental Health.

**Willard O. Thompson**, Woman's Auxiliary of the South Chicago Branch of the Chicago Medical Society, April 5, on Obesity.

**Charles I. Fisher**, Woman's Auxiliary to the Champaign County Medical Society, Champaign, April 8, on Geriatrics.

**Eugene L. Slotkowski**, Austin Junior Woman's Club in Austin, April 13, on Fears and Accidents of Pre-School Children.

**Sanford A. Franzblau**, Norman Bridge School P. T. A., April 20, on Know Your Heart.

**Lectures Arranged Through the Scientific Service Committee of the Illinois State Medical Society:**

**John R. Wolff**, Chicago, Iroquois County Medical Society in Watseka, February 16, on Office Gynecology.

**Lawrence W. Peterson**, Chicago, Rock Island Chapter of the Illinois Academy of General Practice in Moline, February 23, on Diagnosis of Breast Problems.

**Walter J. Reich**, Chicago, Henry County Medical Society in Galva, March 10, on Diagnosis and Management of Common Gynecological Problems.

**Frederick W. Munson**, Chicago, LaSalle County Medical Society in Streator, March 15, on Abnormal Secretions from the Nipple.

**H. R. Oberhill**, Chicago, St. Clair County Medical Society in East St. Louis, April 1, on Epilepsy.

**Matthew J. Brunner**, Chicago Heights, Knox County Medical Society in Galesburg, April 15, on Simplified Rational Treatment of Common Skin Diseases.

**Walter S. Priest**, Chicago, Marion County Medical Society in Centralia, April 15, on The Management of Acute Myocardial Infarction.

**Robert C. Levy**, Chicago, Stock Yards Branch of the Chicago Medical Society, April 15, on Restrictions for Cardiac Patients: Necessary and Needless.

**Harry A. Oberhelman**, Chicago, Whiteside-Lee County Medical Societies in Sterling, April 15, on Fibrocystic Disease of the Breast and Carcinoma.

**Carlo Scuderi**, Chicago, DeKalb County Medical Society in Sycamore, April 27, on The Treatment of Fractures of the Neck of the Femur.

**Joseph A. Hardy, Jr.**, St. Louis, Missouri, Mont-

gomery-Macoupin County Medical Societies in Litchfield, April 27, on Indications for Hysterectomy.

**"All About Baby"** over WBKB, Channel 7.—Since the last issue of the Illinois Medical Journal, the following physicians were scheduled to appear in the telecast **"All About Baby"** which appears daily over Station WBKB:

**Elsie W. Wieczorowski**, member of staff, Children's Memorial Hospital, February 3.

**Helen D. Heinen**, member of the pediatric staff, Evangelical Hospital, February 10.

**C. Edward Stepan**, member of the pediatric staff, St. Luke's Hospital, February 17.

**Daniel J. Packman**, clinical assistant professor of pediatrics, University of Illinois College of Medicine, February 24.

The physicians appearing on **"All About Baby"** are scheduled by the **Educational Committee of the Illinois State Medical Society**. The telecast is produced by the Herbert Laufman Television Productions and is sponsored by Libby Foods and Swift Meats.

## DEATHS

Robert Whitney Baker, Chicago, who graduated at the University of Illinois College of Medicine in 1945, died in Fort Miley Hospital, San Francisco, November 4, aged 33, of bacterial endocarditis. He was a member of the Illinois State Medical Society.

Charles Berkowitz, Chicago, who graduated at Northwestern University Medical School in 1930, died January 11, aged 48. He was a member of the staffs of Mount Sinai Hospital and Winfield Sanitarium, and of the Illinois State Medical Society.

William Orange Coleman, Assumption, who graduated at Hahnemann Medical College in 1903, died in the Decatur and Macon County Hospital, Decatur, December 5, aged 81, of coronary heart disease.

Francis S. Diller, Rantoul, who graduated at the College of Physicians and Surgeons of Chicago in 1895, died November 14, aged 92. He was past president of the Rantoul Township High School Board, had served on the staff of Mercy Hospital in Champaign, and was a member of the Illinois State Medical Society.

Ophius Poston Donovan, Bismarck, who graduated at St. Louis College of Physicians and Surgeons in 1903, died in the Lake View Hospital, Danville, recently, aged 74.

Margaret W. Gerard, Chicago, who graduated at Rush Medical College in 1925, died January 12, aged 59. She was a member of the Illinois State Medical Society and on the staff of the Illinois Children's Home and Aid Society.

Monroe Harris, Bloomington, who graduated at Northwestern Medical School in 1909, died September 23, aged 83, of cerebral hemorrhage.

Adelaide Doolittle Hoeffel, retired, Chicago, who

graduated at the Hahnemann Medical College and Hospital in 1903, died January 19, aged 86. She was a member of the Illinois State Medical Society.

Oscar Willard Michael, Muncie, who graduated at the Medical College of Indiana, Indianapolis, in 1898, died November 14, aged 78. He was a member of the Illinois State Medical Society and of the courtesy staffs at Lake View and St. Elizabeth Hospitals in Danville.

Ole C. Nelson, retired, Oak Park, who graduated at the Chicago Medical School in 1920, died January 16, aged 71. He was a member of the Illinois State Medical Society and formerly medical director of Cook County Hospital.

Arthur R. Rikli, Naperville, who graduated at Rush Medical College in 1907, died February 2, aged 76. He was a member of the Illinois State Medical Society and had been Secretary of the

DuPage County Medical Society for many years.

Otto H. Rohrlack, retired, Chicago, who graduated at Northwestern University Medical School in 1902, died January 18, aged 79.

William P. Schoen, retired, Chicago, who graduated at Rush Medical College in 1895, died February 4, aged 84. He was a member of the Illinois State Medical Society and of the health department staff for 40 years.

D. Henry Taphorn, Effingham, who graduated at Washington University School of Medicine, St. Louis, in 1898, died recently, aged 82. He was a member of the Illinois State Medical Society.

Solomon A. Weiss, Chicago, who graduated at the Chicago College of Medicine and Surgery in 1917, died January 21, aged 63. He was a member of the Illinois State Medical Society and of the staff of Belmont Hospital.

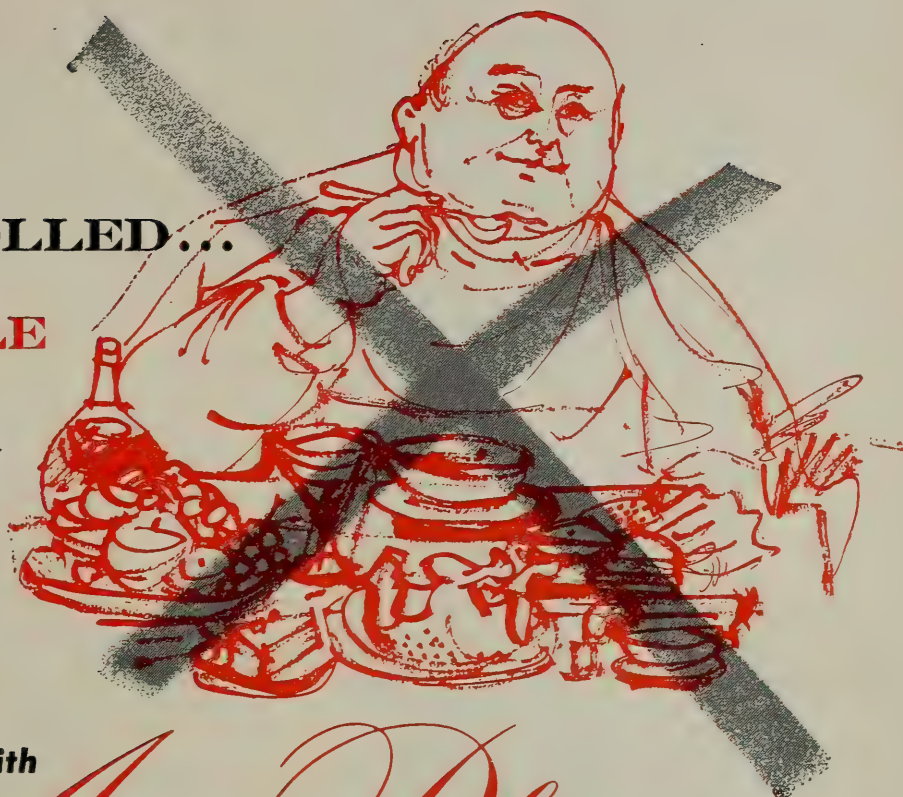
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## WHEN A REPORTER CALLS

It is your Observer's belief that many doctors are too sensitive to medical publicity. There can be no reasonable objection to honest and objective reporting on medical matters, scientific or otherwise. There have been instances where a news story was in questionable taste — not that the physician intended to affront his fellows, but due largely to his lack of knowledge about news gathering and what he should say to the reporter when he calls. It is this which prompted your Observer to write the following paragraphs in the hope that they will be helpful to some of his readers.

The first thing for the doctor to remember is that when the reporter calls, he has been given an assignment. He must, if he wishes to hold his job, report facts, pleasant or unpleasant. Most newspapers expect him to be objective but, being human, his observations are to some extent colored by his personal experiences and his attitude toward life in general. Even when the reporter leans over backward to be fair, the result may or may not be satisfactory to the person or organization whose activities he covers.

The doctor should make up his mind at the beginning of the conversation with the reporter whether he wishes to be identified in the story which is being written and, if so, whether he wishes to be quoted. It will not do to talk first and make the request not to be quoted later. This is not fair to the reporter, who has every right under these circumstances to ignore the request.

The doctor should not give an interview or permit his name to be used in connection with an article describing a scientific procedure unless it is original or, for some valid scientific reason, unique. Your Observer recalls that some years ago in a Midwestern state where he was formerly situated, a physician was widely publicized for an operation on an infant with an "upside down" stomach. The fact was that this operation had been performed before many times by other skilled surgeons. Naturally, the doctor came in for considerable criticism.

Even when the release of scientific information seems justified, the doctor is wise to communicate with his medical society before it is publicized. This suggestion is not offered to afford the society an opportunity to censor the doctor's

*(Continued on page 53)*

## REPORTER (Continued)

statement or the facts to be included in the news release but to help the physician and the reporter to avoid pitfalls which may not be apparent to them.

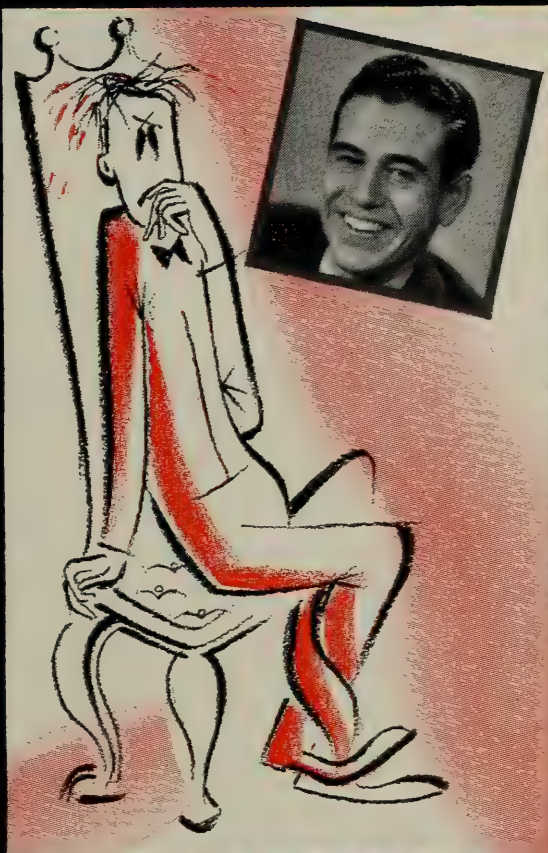
Returning to the use of the doctor's name, this is the most controversial aspect of the physician-press relationship. The subject has come up many times in meetings between newspaper editors, reporters, and physicians. During the recent ANNUAL SCIENTIFIC ASSEMBLY, an unusually able reporter on medical subjects suggested that the society's Committee on Public Information be requested to arrange another conference in which city editors, reporters, and members of the society would participate. Your Observer concurs in this proposal. But whatever this group does in this and other matters pertaining to publicity, satisfactory relations with the press depend more than anything else on how doctors individually deal with the reporters. *In And Out Of Focus by the Observer. M. Ann. District of Columbia, Nov. 1953.*

## BLEEDING AND PERFORATION

The medical aphorism, "Bleeding ulcers do not perforate and perforated ulcers do not bleed," still is quite generally accepted by physicians and surgeons, in spite of rather impressive evidence that both of these disastrous events can occur in the same patient, often at the same time. Although concomitant bleeding and perforated ulcer in the same patient are fortunately rare, the denial of the possibility of their occurrence may cost the life of the patient. *Louis Pelner, M.D., and Walter Puderbach, M.D., Bleeding Ulcers may Perforate, Postgrad. Med., Dec. 1953.*

By proclaiming that pure water, pure air, pure food, decent lodging were essential to the life of man in society, the public-minded physicians and the humanitarians did much toward eliminating the grossest evils of industrial civilization. The fall in the tuberculosis death rate was but one result of the gospel of health living which they preached. *Rene J. Dubos, Ph.D., Am. Rev. Tuberc., July, 1953.*

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## BOOK REVIEWS



GYNECOLOGIC AND OBSTETRIC PATHOLOGY with Clinical & Endocrine Relations. (Third Edition)

With Clinical & Endocrine Relations: By Emil Novak, A. B. M. D., D. Sc. (Hon., Trinity College, Dublin; Tulane), F. A. C. S., F. R. C. O. G. (Hon). 595 pages with 630 illustrations, 19 in color. Third Edition. Philadelphia and London: W. B. Saunders Company, 1952. Price \$10.00.

This work is not large; yet it is replete with detailed description of the gross and the microscopic findings of the many pathological conditions common to the anatomical area. No words are lost in the portrayal of a lesion, but adequate and definite statements portray vividly the variation from the normal findings. Also the differentiation from other lesions possibly somewhat similar or confusing in their resemblance in microscopic structure are delineated definitely. In other words, the differential diagnosis of the pathology under consideration is very elegantly done and with no loss of words or space.

There is no dearth of "cuts" showing the microscopical appearance of almost every item of pathological change considered in the book. Yet these figures lack brilliance as do all such representations in print.

The Author's "professional life has been spent as a Clinician," yet here "his hobby" has taken

form in a treatise on pathology of which he may well be proud, not only of this volume especially but also of the former two editions.

This is a splendid reference book for Pathology in the field of Obstetrics and Gynecology.

C. P. B.

MAY'S MANUAL OF THE DISEASES OF THE EYE, for Students and General Practitioners. 21st edition revised and edited by CHARLES A PERERA, M.D., Associate Clinical Professor, College of Physicians and Surgeons, Columbia University, New York; Attending Ophthalmologist, Presbyterian Hospital, New York. 378 illustrations including 32 plates, with 93 colored figures. Baltimore: Williams & Wilkins Company, 1953. \$6.00

This is the twenty-first edition — the first was in 1909 — of the famous MAY'S MANUAL. As in the predecessors there is a comprehensive presentation of the disorders of the eye and its adnexa.

It is up to date by virtue of many revisions and a few deletions of obsolete items. The newer therapeutic measures and surgical procedures discussed include cortisone and corticotropin, Kronleins operation and retrolental fibroplasia.

New color pictures replace twenty five of the old drawings. In all there are ninety-three

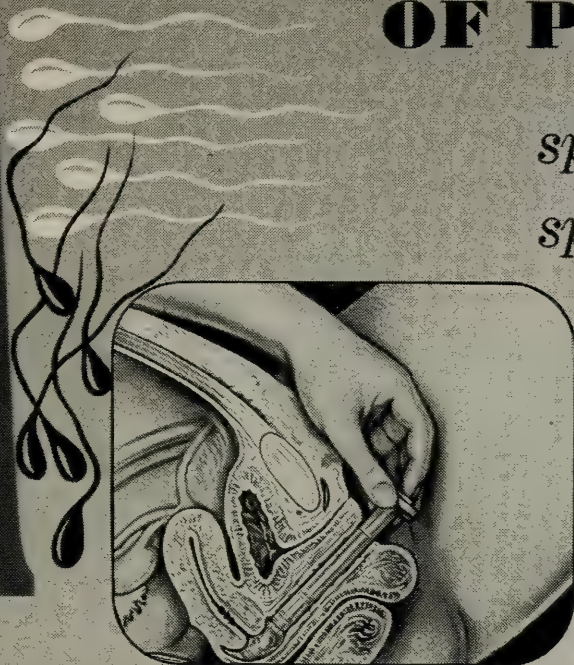
(Continued on page 56)

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\*Active agent, dodecaethyleneglycol monolaurate 5%, in a base of long-lasting barrier effectiveness. 1. Gamble, C. J.: Report to Council on Pharmacy & Chemistry, A.M.A.: J.A.M.A. 153:1019, 1953.

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## BOOK REVIEWS (Continued)

colored figures among the 738 illustrations which offers an abundance of pictures and diagrams.

The size and shape of the book remains the same. The twenty-six chapters present concise, practical, authoritative and systematically arranged material for those who wish ophthalmologic information.

MAY'S DISEASES OF THE EYE is especially recommended for students and general practitioners.

L. P. A. S.

"I cannot so properly say that he died of one disease for there were many that had consented and laid down their heads together to bring him to his end. He was dropsical, he was consumptive, he was surfeited, was gouty, and, as some say, had a tang of the pox in his bowels. Yet the Captain of all these men of death was the consumption, for 'twas that that brought him down to his grave." John Bunyan, (quoted by G. Lissant Cox, M.D., and H. F. Hughes, A.M.) *Tubercle*, Sept., 1953.

## EXPLOSIVE REACTION... OR GENTLE EVACUATION?

"In acute constipation, the cathartic of choice is the . . . one which will produce a prompt and complete evacuation *without excessive purgation*." (Cornell Conference on Therapy, Vol. III, p. 279)

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"Bile has a *mild* laxative action . . ." (U. S. Dispensatory, 24th Edition: 808, 1947)

" . . . bile per se is stimulating to the movements of the bowel so that an increase in bile flow has a natural stimulating effect." (Shallenberger, P. L. and Kerr, P. B., *Postgrad. Med.* 13:32, 1953)

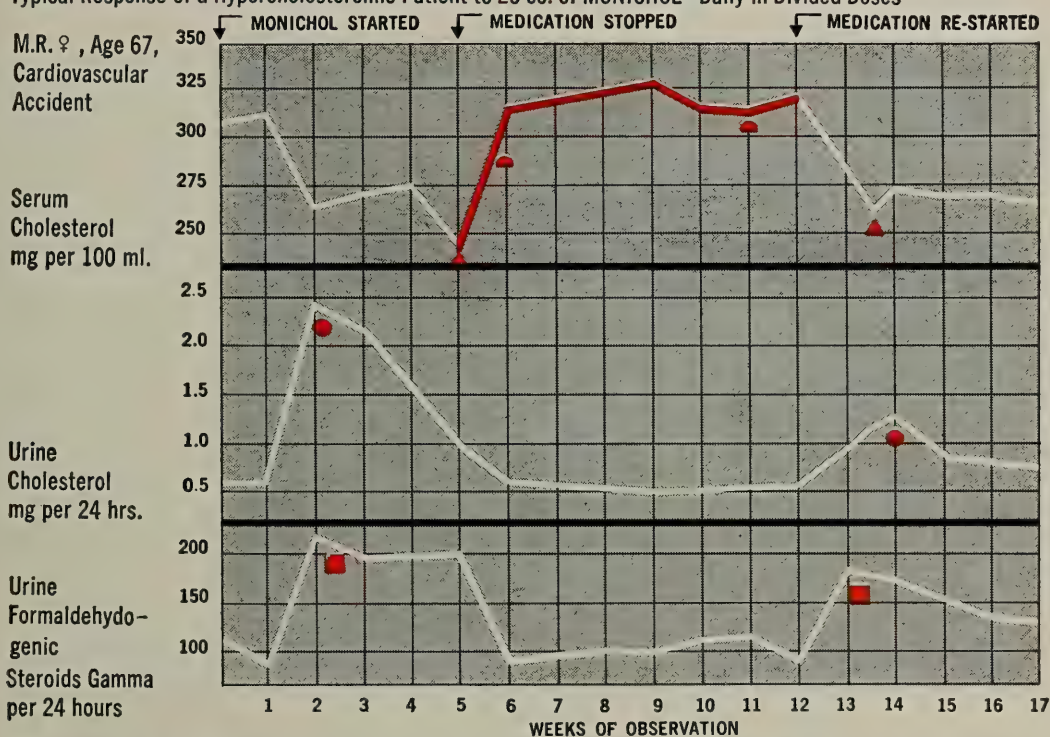
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\*\*Sherber, D. A., and Levites, M. M.: Hypercholesteremia. Effect on Cholesterol Metabolism of a Polysorbate 80-Choline-Inositol Complex (MONICHOL) J.A.M.A. 152:682 (June 20) 1953.

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## BOOKS RECEIVED

The following books have been received for reviewing, and are herewith acknowledged. This listing should be considered as a sufficient return for the courtesy of the sender. Books that appear to be of unusual interest will be reviewed as space permits each month. Readers desiring additional information relative to books listed, may write the Editor who will gladly furnish same promptly.

**A HANDBOOK ON DISEASES OF CHILDREN** — including dietetics and the common fevers. By Bruce Williamson, M.D., Edin., F.R.C.P. Lond., Physician, Children's Dept. Royal Northern Hospital, Lond.; Physician, Children's Hospital, Northaw; Physician, Prince of Wales General Hospital, London; Physician, Barnet General Hospital; Physician, Enfield War Memorial Hospital; Lecturer, North London Post-Graduate Institute. Seventh Edition. E. & S. Livingstone Ltd., Edinburgh and London, 1953. 467 pages. \$5.00.

**MANUAL OF PSYCHOLOGICAL MEDICINE** for Practitioners and Students. By A. F. Tredgold, M.D., F.R.C.P., F.R.S.E., Consulting Physician to University College Hospital, London, and R. F. Tredgold, M.A., M.D., D.P.M., Physician to the Department of Psychological Medicine, University College Hospital, London. Third Edition. Bailliere, Tindall and Cox, 7

*(Continued on page 60)*

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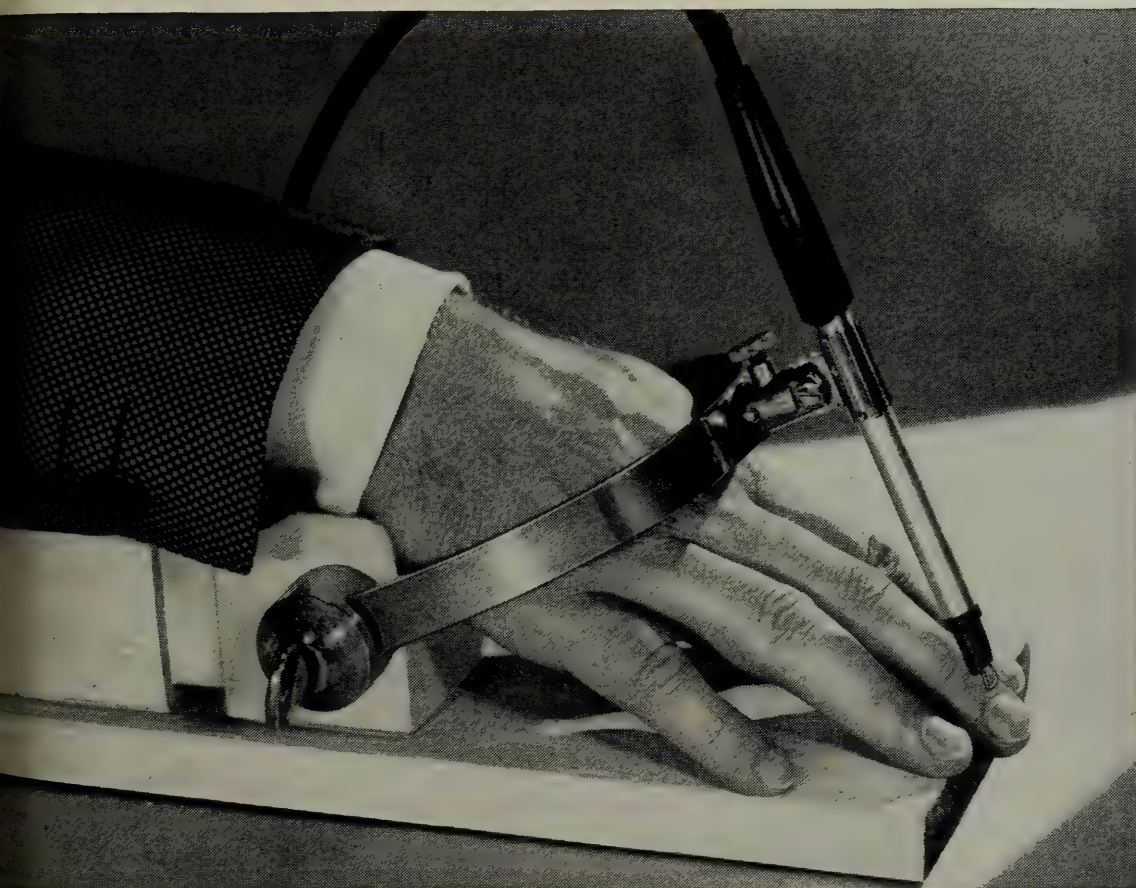
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## BOOKS RECEIVED (Continued)

and 8 Henrietta Street, W. C. 2, London, 1953. 328 pages. \$7.00.

**SALT AND THE HEART.** By Edward T. Yorke, M.D., Attending Cardiologist, Alexian Brothers Hospital, Associate Cardiologist, St. Elizabeth Hospital, Dispensary Physician, Elizabeth General Hospital, Elizabeth, N. Y., Consultant in Medicine, Rahway Hospital, Rahway, N. J. Publisher, Drapkin, 36 East 19th Street, Linden, N. J., 83 pages. \$3.45.

**THE CHILD, HIS PARENTS AND THE NURSE.** By Florence G. Blake, R.N., M.A., Associate Professor of Nursing Education, (Nursing Care of Children) University of Chicago. Foreword by Adrian H. VanderVeer, M.D., Formerly Associate Professor of Pediatric Psychiatry, University of Chicago. J. B. Lippincott Company, Philadelphia, London, Montreal. 440 pages. \$5.00.

**GLOBAL EPIDEMIOLOGY — A Geography of Disease and Sanitation.** By James Stevens Simmons, B.S., M.D., Ph.D., Dr. P. H., Sc. D. (Hon.) Brigadier General, United States Army, Retired, Dean and Professor of Public Health, Harvard University School of Public Health, and Tom F. Whayne, A.B., M.D., M.P.H., Dr. P. H., Colonel, M.C., United States Army; Chief, Preventive Medicine Division, Office of the Surgeon General, United States Army, and Gaylord W.

Anderson, A.B., M.D., Dr. P. H., Mayo Professor and Director, School of Public Health, University of Minnesota, and Harold MacLachlan Horack, B.S., M.D., Member of Staff, Department of Medicine and Section of Cardiology, Ochsner Clinic, New Orleans; Instructor in Medicine, Tulane University School of Medicine. Associate Author — Ruth Alida Thomas, B.A., A.M., M.P.H., Research Associate, School of Public Health, University of Minnesota; Instructor, Department of Tropical Public Health, Harvard University School of Public Health, and collaborators. Volume Three. The Near and Middle East. J. B. Lippincott Company, Philadelphia, London and Montreal. 357 pages. \$12.00.

**MUSIC THERAPY.** Edited by Edward Podolsky, M.D., Department of Psychiatry, Kings County Hospital, Brooklyn, N. Y., Philosophical Library, New York. 335 pages. \$6.00.

**RAT QUALITY, A CONSIDERATION OF HEREDITY, DIET AND DISEASE.** Proceedings of the Symposium held at Columbia University, College of Physicians and Surgeons, New York, New York, January 31, 1952. W. E. Heston, G. E. Jay, Jr., H. Kaunitz, H. P. Morris, J. B. Nelson, S. M. Poiley, C. A. Slanetz, Lois M. Zucker and T. F. Zucker. November, 1953. Copyright, 1953. The National Vitamin Foundation, Incorporated, 15 East 58th Street, New York 22, New York. 138 pages. \$2.50.



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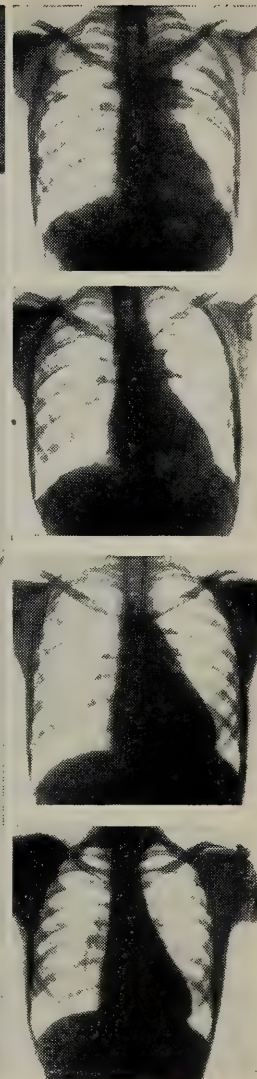
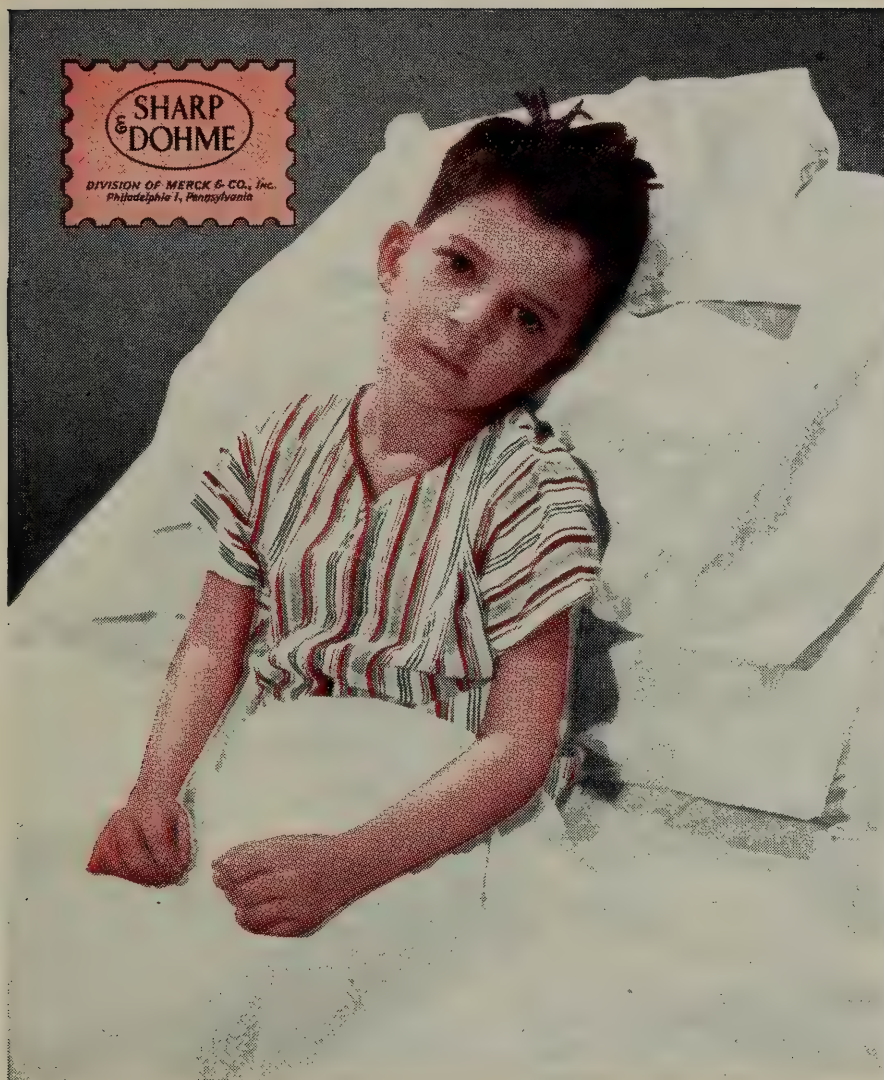
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## VIABILITY OF TUBERCLE BACILLI IN VIVO WITH AND WITHOUT CHEMOTHERAPY

By Rene J. Dubos, Ph.D., *The American Review of Tuberculosis*, June, 1953.

The fact is now clear that, despite the availability of several types of drugs highly effective against tubercle bacilli *in vivo*, it is very difficult, if not impossible, to eradicate infection from human patients, even by prolonged chemotherapy. In contrast is the other fact, long known to pathologists, that bacilli tend to disappear spontaneously and without any form of therapy from certain types of lesions; in particular from cold abscesses and from closed caseous areas. This is well confirmed by the recent observation that it is at times difficult to recover living bacilli from resected lung lesions in patients who have received no chemotherapy. Instead of being contradictory, however, these two phenomena correspond in reality to two independent aspects of the pathogenesis of tuberculosis. In this connection some experimental findings bearing on this problem are presented.

The failure of drugs to kill all bacilli in in-

fectured tissues has been observed, not only in human tuberculosis, but also in many types of experimental infections. This may be illustrated by examples taken from studies in mouse tuberculosis.

Results obtained independently by Dr. McCune of the Department of Medicine of the New York Hospital, and in our own laboratory, may be condensed very briefly. Mice were infected intravenously with doses of culture containing approximately from one hundred to one million organisms. Several strains were used, some virulent, other attenuated. The animals were treated with either streptomycin or isoniazid, or simultaneously with both drugs, the therapy being started on the very first day of infection and continued thereafter. Some of the animals were sacrificed at weekly intervals during three months. Although no macroscopic evidence of tuberculous lesions could be recognized in any animal, living tubercle bacilli could be recovered from all of them, even when BCG was used and when therapy had been continued for 85 days. Moreover, bacillary invasion of the tissues be-

(Continued on page 64)

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Literature available on request. Write Medical Service Division, Ciba Pharmaceutical Products, Inc., Summit, N.J.

1. SIMON, S. W.: ANN. ALLERGY 11: 218, 1953. 2. KESTEN, B. M.: ANN. ALLERGY 6: 408, 1948. 3. LOEW, E. R.: MED. CLIN. N. AM. 34: 351, 1950.

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## TUBERCLE BACILLI (Continued)

gan uniformly within a few days after discontinuance of the drugs. Several lines of experimentation have thrown light on the mechanism of this disturbing phenomenon.

First there must be recognized the all important fact that, despite early claims, it is practically impossible to sterilize cultures of tubercle bacilli *in vitro* by adding to them either streptomycin or isoniazid. True enough, most of the bacilli appear to die rapidly in contact with the drugs, but a few survive prolonged exposure to them. The phenomenon probably has its counterpart *in vivo*. It is probable, in other words, that a certain percentage of the bacilli in an infected individual survive exposure to the drugs, not because they have developed hereditary "drug resistance," but because they exist in a form different from that in which observations are usually made.

Another reason for the difficulties experienced in eradicating infection may be that *in vivo* a large percentage of the tubercle bacilli are present, not free in body fluids, but instead within

*(Continued on page 68)*

*In spastic and occlusive vascular diseases*

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## TUBERCLE BACILLI (Continued)

phagocytic cells. Experiments in tissue cultures have revealed that the inhibitory power of streptomycin fails to manifest itself against the growth of bacilli which have been engulfed by monocytes—a fact which certainly contributes to the inability of this drug to eradicate infection.

This explanation, however, cannot serve in the case of isoniazid, for this drug is just as effective intracellularly as it is extracellularly, in tissue cultures at least. It must be assumed, therefore, either that the bacilli can be engulfed by cells which behave toward the hydrazide in a manner other than that of the monocytes or, more likely, that some factor in the *in vivo* environment antagonizes antibacterial activity. The problem of the existence in tuberculous lesions of substances capable of inhibiting antimicrobial drugs is one worthy of attention. Areas of necrosis, particularly of caseation necrosis, contain a variety of partially broken-down tissue components of unknown chemical composition, many of which are

(Continued on page 70)

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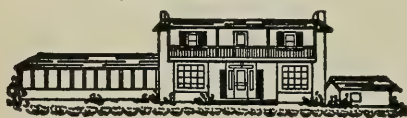
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## TUBERCLE BACILLI (Continued)

likely to act as drug inhibitors. The finding that drugs penetrate caseous matter is no warrant, therefore, that they can exert their antibacterial action in the physiochemical environment of the lesion.

Bacilli often disappear spontaneously from certain types of lesions, without the help of chemotherapy. This fact is so well documented that there is no need to give more evidence of it. The presence in animal tissues of several substances might be responsible for this effect. These substances are: (a) The naturally occurring amines, spermine and spermidine. (b) The enzyme lysozyme which does not lyse the bacilli, but can kill them rapidly even in highly dilute solution (1:100,000). (c) A basic polypeptide which has been recently isolated from the thymus gland.

Organic acids accumulate in and around tuberculous lesions as a result of the anaerobic metabolism of inflammatory cells and of the activity of the lipolytic enzymes released during necrosis. Bacilli are unable to multiply in ordinary media, and fail to infect laboratory animals, after exposure for several weeks to physiologic concentration of the sodium salts of several organic acids. Sterilization of the cultures occurs when the atmosphere is completely or partially anaerobic and when the CO<sub>2</sub> tension is higher than normal. These are precisely the conditions prevailing in certain types of closed lesions.

There is another problem which has loomed very large during the past two years, namely, whether the bacillary forms which can be seen in resected lesions but which fail to grow in culture media and to cause disease in experimental animals should be regarded as "dead," or merely as dormant but potentially viable, bacilli. None of the evidence adduced so far is of much help in answering it. In my opinion, the techniques used by the various investigators were not adequate to determine the potential viability of dormant bacillary forms.

Organisms in which respiration is at a low level may merely have exhausted an essential metabolite, or be in a resting form akin to that of spore, and yet may be able to multiply when placed in the proper environment. This type of apparent death followed by revival under other

(Continued on page 72)

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1. Van Cauwenberge, H.: Lancet 261:374, 1951; Van Cauwenberge, H., and Heusghem, C.: Proc. Soc. Exper. Biol. & Med. 80:51, 1952. 2. Pelloja, M.: Lancet 1:233, 1952. 3. Paul, W.D., et al.: J. Am. Pharm. A., Scient. Ed. 39:21, 1950.

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### TUBERCLE BACILLI (Continued)

conditions is common in many fields of microbiology.

Finally, one should not overlook the fact that tubercle bacilli are present not only in the parenchymatous lesions but also in lymphatic tissues. In cattle which have received a virulent infection after vaccination with BCG and show no overt sign of tuberculosis, the virulent bacilli can invariably be found in lymph nodes for months and years thereafter. It is known that even BCG bacilli can persist for several years in the lymph nodes of man and animal. Laboratory experiments have revealed, furthermore, that prolonged therapy with isoniazid fails to eradicate BCG infection.

All these facts leave the impression that no technique is as yet available to bring about with certainty a complete eradication of the bacilli from infected tissue. After antimicrobial drugs have ceased to exert their restraining influence on infection, either because the infective organisms have become resistant to them or because therapy has been interrupted, only the resistance of the host can act as a brake on reactivation of

disease caused by the bacilli surviving here and there, detectable or not by the classical methods of pathology and bacteriology.

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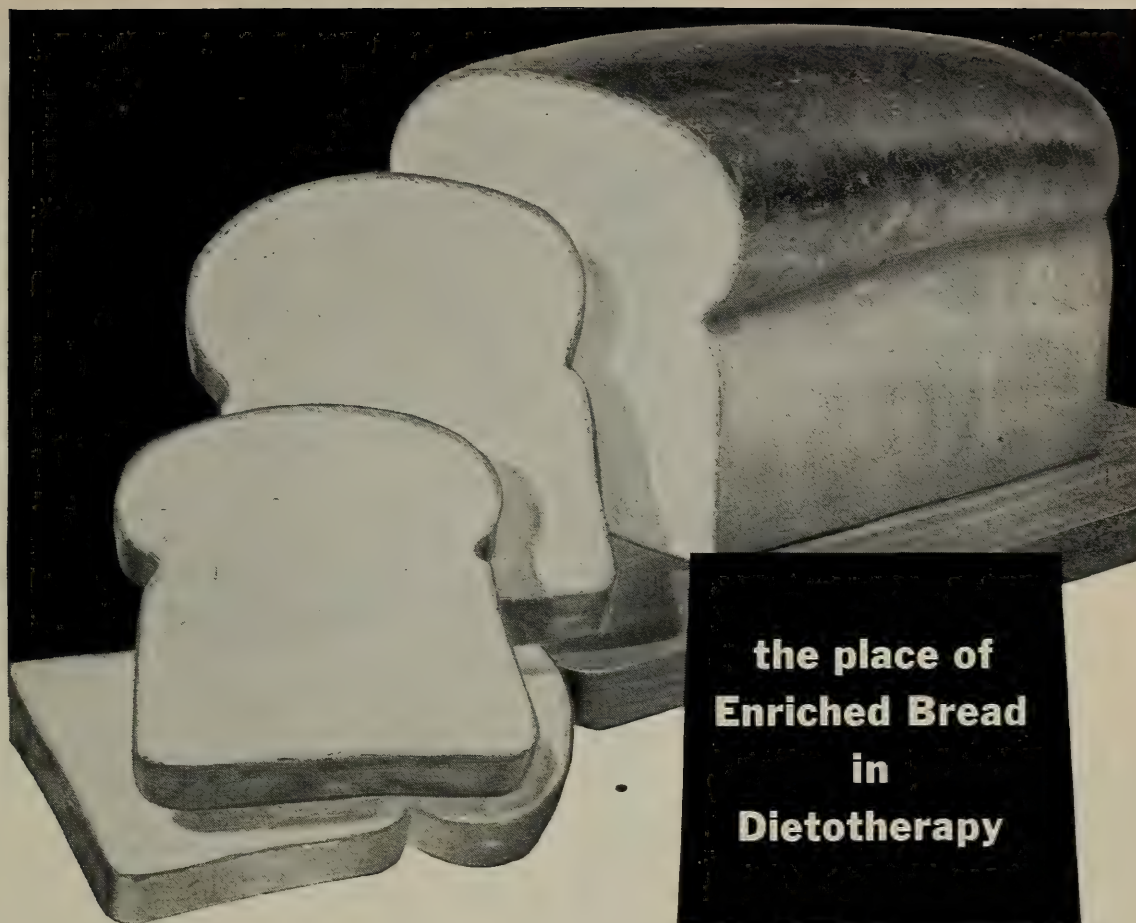
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Enriched bread, today the bulk of commercial bread, contains important amounts of added B vitamins, iron, and in most instances nonfat milk solids. Because it supplies significant quantities of essential nutrients that are metabolically required regardless of the condition under treatment, enriched bread deserves a place in virtually all special purpose diets, including those for weight reduction. In the latter, two or three slices of enriched bread, the quantity usually allowed, contribute needed calories as well as essential nutrients in noteworthy amounts.

In compliance with government regulations, enriched bread, per pound, provides at least 1.1 mg. of thiamine, 0.7 mg. of riboflavin, 10 mg. of niacin, and 8 mg. of iron. By and large, enriched bread as marketed also supplies about 400 mg. of calcium and 39 Gm. of protein. Since the protein consists of flour and milk proteins, it is biologically valuable for growth as well as tissue maintenance. Thus enriched bread can make a significant contribution to the satisfaction of daily requirements in dietotherapy.

Bread rounds out virtually every diet. Because it is readily digested and contains only an insignificant amount of indigestible residue, enriched bread is rarely—if ever—contraindicated.



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### *...in Muscular Spasm and Tremor*

Mephate 'Robins' relaxes skeletal muscle spasm and tremor without impairing strength; and allays nervous tension and anxiety without dimming consciousness.

• Mephate (0.25 Gm. of mephenesin and 0.30 Gm. of glutamic acid hydrochloride in each capsule) has been shown to be more effective clinically than mephenesin alone.

# MEPHATE<sup>®</sup>

CAPSULES

Robins

A. H. ROBINS CO., INC. • Richmond 20, Virginia  
Ethical Pharmaceuticals of Merit since 1878

## YOU WERE THERE

Traditionally in March millions of citizens in every part of the country open their hearts and their purses to support the humanitarian services of the American Red Cross. This organization is a great fellowship of good will in which all citizens are welcome.

When you join the Red Cross you identify yourself with each individual act of mercy this great organization performs anywhere in the world, as surely as if you personally extended a helping hand.

You were there in Illinois the last fiscal year of 1952-53, when multiple tornadoes dipped out of the skies to wreak havoc and death, and when fires and other calamities left chaos in their wake. In all, 136 persons were killed or injured and 4,449 buildings were destroyed or damaged, as 31 disasters struck in 10 counties of the state. You spent \$74,413 to help 1,824 persons who suffered disaster injury or loss.

You helped prevent loss of life, too, as you and the Red Cross trained 45,245 persons in first aid, 67,937 in swimming and life saving, and 18,096 in home nursing.

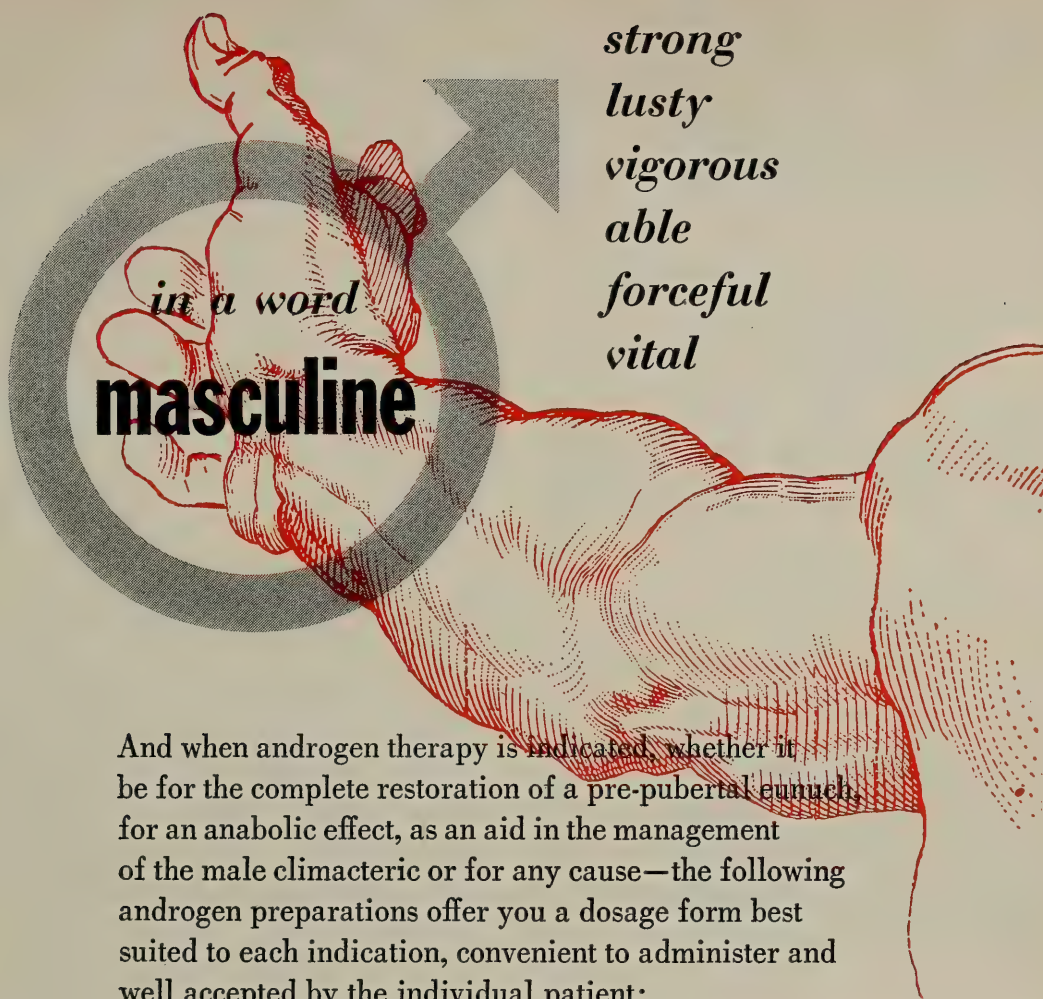
But your efforts didn't stop there. You came to the aid of 62,175 servicemen or veterans and their families in Illinois and, when money was needed, spent \$357,417 in their behalf. To an additional 51,717 individuals and families, you provided information and similar Red Cross services.

Through your help, 1,104,535 youngsters were introduced to Red Cross principles through the Junior Red Cross program, now active in 3,854 elementary and secondary Illinois schools. These students filled and sent overseas 17,338 gift boxes for needy foreign children, and raised \$15,377 for the National Children's Fund.

Your generosity, not only in terms of money but of your own time, caused a grand total of 583,176 volunteer hours of service to be chalked up in Illinois, as 9,341 trained volunteers worked to provide Red Cross services to their communities, to their hospitals, and to military personnel. In all, you helped produce 1,198,242 garments, surgical dressings, and comfort items in your state last fiscal year.

Nationally, the helping hand of the Red Cross collected 4,121,200 pints of blood in that year

(Continued on page 78)



And when androgen therapy is indicated, whether it be for the complete restoration of a pre-pubertal eunuch, for an anabolic effect, as an aid in the management of the male climacteric or for any cause—the following androgen preparations offer you a dosage form best suited to each indication, convenient to administer and well accepted by the individual patient:

**SYNANDROL**\* brand of testosterone propionate in sesame oil: 25 mg., 50 mg. and 100 mg./cc. in 10 cc. multiple-dose vials and in single-dose Steraject® disposable cartridges.

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**SYNANDROTABS**\* brand of methyltestosterone tablets, for oral use: 10 mg. and 25 mg., bottles of 25 and 100.

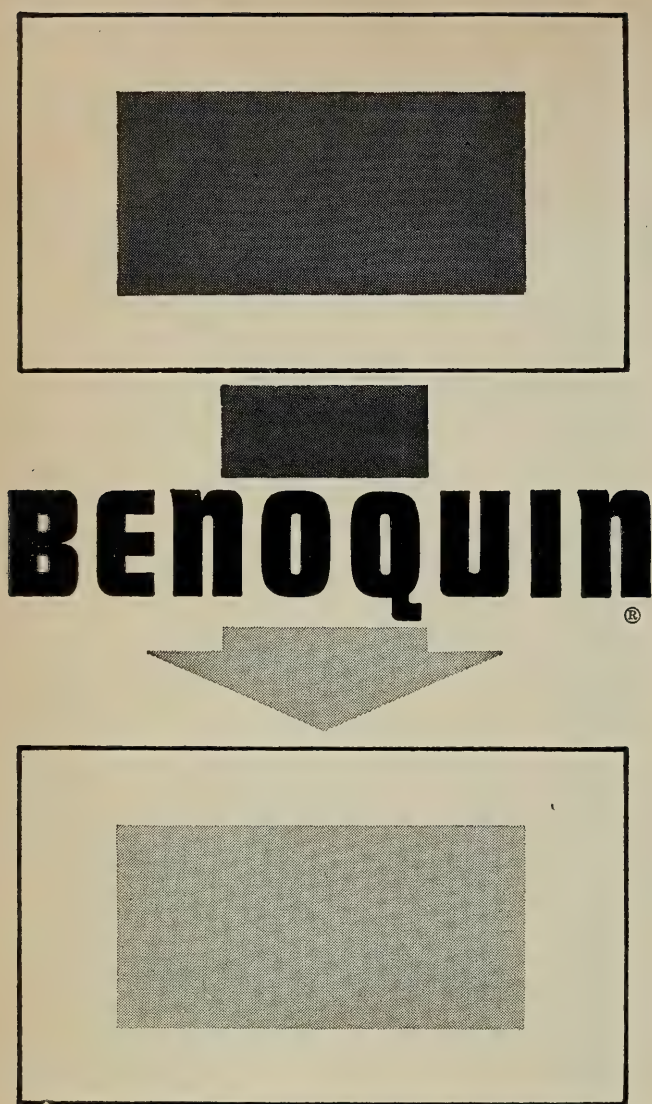
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If erythema or dermatitis develops, discontinue the medication. The medication is not effective in hyperpigmentation resulting from pigments other than melanin.

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BRYAN, OHIO

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During the fiscal year, there were 100 Red Cross volunteers to every paid worker, and three of these volunteers were on duty every minute of that year to bring Red Cross services to neighbors. You spent \$164 each of those minutes to meet human needs — an incredible record of good deeds.

Your time, your energy, your money make these Red Cross services possible. This year's Red Cross goal is \$85,000,000 and 30,000,000 members. In your hands is the measure of what Red Cross can do in the year ahead for the stricken and troubled who call for the help they must have.

**SPEECH DEFECTS**

The causes of speech disorders are to be sought in the genetic record of the child; in the conditions of his birth and early development; and in the physical, environmental, and personality factors which condition the first five or six years of his life. Since most speech disorders appear in the early developmental years it follows that their prevention, elimination, or amelioration should be effected early in child life. With proper physical care and adequate environmental control, at least 75 per cent of the speech problems which plague adult life could be prevented before a child reaches puberty. *Harlan Bloomer, Pediatric Responsibility to Children With Speech Defects. Postgrad. Med., Dec. 1953.*

The differentiation of fungal diseases from tuberculosis is extremely important in view of the mental trauma inflicted upon patient and family by a diagnosis of tuberculosis. It is perhaps even more important that the patient not be incapacitated and put at bed rest because of a false diagnosis of tuberculosis when a fungal infection, actually present, might be adequately followed and observed without limitation of activities. Michael L. Furcolow, M.D., Myron J. Willis, M.D., Lawrence E. Wood, M.D., and Herbert L. Mantz, M.D., *Am. Rev. Tuberc., Feb., 1954.*

**to support the healthy...**

*Viterra®*

*a vitamin-mineral formulation  
of 21 balanced factors,  
supplementing the depleted diet*

**each capsule of *Viterra®* contains:**

Vitamin A .....	5,000 U.S.P. Units
Vitamin D .....	500 U.S.P. Units
Vitamin B <sub>12</sub> .....	1 mcg.
Thiamine Hydrochloride .....	3 mg.
Riboflavin .....	3 mg.
Pyridoxine Hydrochloride .....	0.5 mg.
Niacinamide .....	25 mg.
Ascorbic Acid .....	50 mg.
Calcium Pantothenate .....	5 mg.
Mixed Tocopherols (Type IV) .....	5 mg.
Calcium .....	213 mg.
Cobalt .....	0.1 mg.
Copper .....	1 mg.
Iodine .....	0.15 mg.
Iron .....	10 mg.
Manganese .....	1 mg.
Magnesium .....	6 mg.
Molybdenum .....	0.2 mg.
Phosphorus .....	165 mg.
Potassium .....	5 mg.
Zinc .....	1.2 mg.

**to fortify the sick...**

*Viterra®  
Therapeutic*

*high-potency capsules  
specifically designed to  
meet increased nutritional  
needs during illness*

**each capsule of**

*Viterra Therapeutic*

**contains:**

Vitamin A .....	25,000 U.S.P. Units
Vitamin D .....	1,000 U.S.P. Units
Thiamine Mononitrate .....	10 mg.
Riboflavin .....	5 mg.
Vitamin B <sub>12</sub> .....	5 mcg.
Niacinamide .....	100 mg.
Ascorbic Acid .....	150 mg.
Calcium .....	103 mg.
Cobalt .....	0.1 mg.
Copper .....	1 mg.
Iodine .....	0.15 mg.
Iron .....	10 mg.
Magnesium .....	6 mg.
Manganese .....	1 mg.
Molybdenum .....	0.2 mg.
Phosphorus .....	80 mg.
Potassium .....	5 mg.
Zinc .....	1.2 mg.



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*Chicago 11, Illinois*



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*on the shores of Lake Michigan*

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The rates for Alaska and Puerto Rico were substantially higher than the rate for Arizona. No doubt part of the difference in rates reflects the relative effectiveness of case finding and reporting in each State. On the other hand, it seems probable that large differences in the rates generally indicate actual differences in the incidence of the disease. Div. of Chronic Disease and TB, PHS, Pub. Health Reports, Nov., 1953.

## DISLOCATED ANKLES

Many so-called "sprained" ankles are not sprains at all. They are in reality much more serious injuries—spontaneously reduced dislocations of the ankle joint. Following a forcible inversion injury of the ankle, the lateral ligaments are often partially or completely torn, allowing the talus to dislocate from the ankle mortise without a fracture of any of the bones making up the ankle joint. In all except rare cases following severe trauma, such a dislocation is reduced spontaneously by the pull of the peroneal muscles. The usual x-ray examination shows no fracture or deformity of the ankle joint and the diagnosis, by exclusion, is "sprained ankle." Since the true injury remains hidden to the usual methods of examination, we have chosen to refer to it as an occult dislocation of the ankle. *D. Keith Millett, M.D., and Myron O. Henry, M.D., Minneapolis, Minnesota, Occult Dislocation of the Ankle. Minnesota Med., November, 1953.*

The treatment of advanced active pulmonary tuberculosis is bed rest fortified by antimicrobial medication. Eli H. Rubin, M.D., N.Y.S. J. of Med., June 15, 1953.

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## Neurological Complications of Spinal Anesthesia

### A Statistical Study of More Than 10,000 Consecutive Cases

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Chicago

A four year study of 10,166 consecutive spinal anesthetics administered at a Veterans Hospital during the years 1948-1951 inclusive is presented. An effort was made to study the cases with a view to finding any significant neurological conditions which might be attributed to the administration of the anesthetic.

A total of 10,166 consecutive spinal anesthetics were included in the study. These were distributed by years as follows: (Figure 1)

YEAR	NO. OF SPINALS
1948	2472
1949	2670
1950	2736
1951	2288
TOTAL	10,166

Figure 1.

These represent all the spinal anesthetics administered at the hospital during the years listed. More recent cases were excluded from the study in order to allow sufficient time for delayed complications, such as adhesive arachnoiditis to appear in follow-up studies or return admissions.

Presented before the section on Anesthesiology, 113th Annual Meeting, Ill. State Med. Soc., May 19, 1953.

From the V.A. Hospital, Hines, Illinois and the University of Ill. College of Medicine.

In studying the records, only neurologic complications were sought, since these are the ones which are so controversial and have occasioned so much discussion. Other complications and sequelae, such as vascular complications did not come within the scope of this study.

Some of the various complications particularly sought were as follows. (Figure 2)

#### TYPES OF COMPLICATIONS SOUGHT

Cerebro-vascular accident within 10 days of Spinal  
Transverse myelitis (para or quadriplegia)  
Radiculitis  
Peripheral nerve lesions  
Foot drop  
Persistent headache (longer than 1 week)  
Neuritides  
Paralyses  
Muscular weakness  
Arachnoiditis, meningitis, meningismus  
Deafness  
Strabismus or other cranial nerve lesions  
Herniated intervertebral disc.  
Persistent lower bowel and bladder dysfunction  
Cauda equina syndrome  
Chronic backache  
Any other neurologic conditions

Figure 2

This list is representative of the complications most frequently reported by others.

The administration of the anesthetics was conducted by a rather large group of individuals varying widely in experience and training. Some were anesthesiology consultants, others staff or attending anesthesiologists, still others anesthesiology residents and finally surgical residents assigned for a three month training period to the anesthesia service.

The method of study consisted of reading the operative note and discharge summary of all patients who had spinal anesthesia during the years listed, as well as any subsequent admissions up to the present time.

The complete hospital records were examined in all cases where death occurred while the patient was hospitalized or where the preliminary inspection indicated any possibility of neurologic complications, i.e. any cases, regardless of etiology, in which any of the above diagnoses were established.

It is realized that this method of investigation has some shortcomings since there is the possibility that some complications may have been missed due to failure of the medical personnel to record complications. Some may have been missed also because of failure of the patient to complain or to return for further treatment.

It is felt however that these undiscovered complications are minimal both in number and severity. This is especially true of the more severe and significant types of complications. There are several good reasons for this belief. First, this is a 100% teaching hospital. Great stress is laid upon the maintenance of complete and accurate clinical records. A large staff is employed solely for the purpose of carrying all clinical diagnoses to the discharge summary, coding, indexing and filing them. Therefore it is quite unlikely that any serious complications are missed for lack of adequate records. Secondly, it is rather unlikely that patients would fail to complain or return for further care in the event of complications, as there is always the factor of increased monetary benefits in the event of increased disability, since this is a government veterans hospital.

Of the 10,000 records over 500 complete charts were examined, since the operative records suggested the possibility of complications. It be-

came obvious that in all but 18 cases there was no possible connection with the administration of spinal anesthesia. These 18 form the basis of this paper.

The majority of the 500 cases studied in detail were ruled out by perusal of the charts, on the basis of one or more of the following reasons:

#### *Cases excluded as Neurologic complications*

1. Neurologic condition existed prior to spinal and unchanged thereby.
2. Neurologic condition due to causes other than spinal anesthesia.
3. Death had no connection with anesthesia.
4. Death was due to complications other than neurologic.

After eliminating all obviously unrelated cases there remained eighteen which will be discussed at this time.

Thirteen of these cases fall into five rather broad categories as follows: (Figure 3)

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#### NEUROLOGIC COMPLICATIONS OF SPINAL ANESTHESIA 10,166 CASES 1948-1951 inclusive

- |                                                                      |                         |
|----------------------------------------------------------------------|-------------------------|
| 1. Cerebro-vascular accidents within<br>10 days of spinal anesthesia | 4 cases                 |
| 2. Aseptic benign meningitis with<br>recovery                        | 1 case                  |
| 3. Persistent headache over 1 week                                   | 3 cases                 |
| 4. Chronic backache                                                  | 2 cases                 |
| 5. Cardiac arrest coincident with<br>spinal anesthesia               | 3 cases<br>(1 recovery) |
- 

Figure 3

Category 1. There were four cerebro-vascular accidents which occurred within ten days of spinal anesthesia. One such case is as follows:

A.C. — a 55 year old male had a procaine spinal (100 mgm in 5cc) for a circumcision. Blood Pressure had previously been recorded at 180/100 on several occasions. Immediately pre-anesthetic it was 112/76 with pulse of 68. During anesthesia it fell as low as 100/60. Approximately 12 hours post anesthetic, at 3:30 AM patient fell to the floor. Cerebrovascular accident was diagnosed. Complete right hemiparesis ensued. Blood Pressure at that time was 136/80.

There is no evidence available to show that the spinal caused this CVA. The Blood Pressure had already fallen prior to administration of the spinal anesthetic. The preanesthetic medication could be as much to blame as the anesthetic. The 3 other cerebro-vascular accidents were similar.

It is established that a profound fall in blood pressure can cause cerebral thrombosis. This is more or less regardless of the cause of the fall. It is also established that spinal anesthesia can cause hypotension. Therefore it is quite within the realm of probability that in susceptible individuals, e.g. those with cerebral arteriosclerosis, any uncorrected hypotension following spinal anesthesia might result in a cerebral vascular accident. Whether any of the 4 cases in this series were so caused is not absolutely determined. It is a possibility that the Spinal anesthesia played a part in the causation of these accidents, and they are therefore reported. Regional anesthesia was really indicated in these cases.

2. One case of benign aseptic meningitis was recorded: CKH, a 40 year old male underwent cholecystectomy under spinal anesthesia. Three days postoperatively he developed severe headaches when he was allowed out of bed. The headaches were less severe when he was lying down. Photophobia and sensitivity to noise accompanied them as did nausea and nuchal rigidity. 45 days later, the spinal fluid pressure was very low. After injecting 40cc of sterile saline, spinal fluid was obtained with 207 mgm% of protein and 133 cells. The headaches continued for a total of 55 days at which time the cell count was 10 and protein 130 mgm%. Follow up examination two years later revealed no residuals. Culture and smear of cerebrospinal fluid were negative at all times. This is an anesthetic complication. It was probably due to chemical irritation or some break in technic. Low grade infection must be considered even in view of the negative smears and cultures.

3. Three cases are reported of persistent headache of more than one week's duration. This differs from the preceding case only in degree. One such case lasted 2 months, the second two weeks, and the third on week. Cases of headache clearing in less than one week were not considered worthy of inclusion in this study, even though

they are extremely undesirable and unpleasant and are economically and scientifically spinal complications, they were not part of the subject we chose to study.

Headache which follows spinal anesthesia is probably due to the anesthesia if it meets certain criteria as follows:

1. The headache is usually occipital if due to spinal.
  2. There may be nuchal rigidity accompanying the headache.
  3. The assumption of the supine position ordinarily affords relief with return of the headache upon assuming the erect position.
  4. Ordinary analgesics such as aspirin do not completely relieve the pain.
  5. A tight abdominal binder or extradural injection will frequently relieve the pain.
4. Two cases of chronic backache are reported. Both were given diagnoses of "chronic lumbosacral strain." A typical case history:

E.R.S. a 38 year old male had a left inguinal hernia repaired under spinal anesthesia. He had no history or complaints relative to his back at that time. Since then he has had three admissions for treatment of chronic lumbosacral strain.

Both patients were obese and there is no evidence that the spinal is to blame. On the other hand there is no evidence to show that the spinal anesthetic was completely blameless. The good muscular relaxation afforded by spinal anesthesia may result in flattening of the normal lumbar curve when the patient is placed in the supine position without a small pillow or other support in the lumbosacral region. Thus it is difficult at this time to state whether the two cases of backache were or were not due to the spinal anesthesia. This condition can follow any anesthetic technic that relaxes the musculature and permits abnormal stresses to occur. It is especially likely to happen when lithotomy or other abnormal positions are employed.

5. Cardiac arrest coincident with spinal anesthesia occurred in 3 cases. Two of these were, however, moribund patients scheduled for amputation following iliac thrombosis. In these, poor judgment as to the advisability of administering any anesthetic other than perhaps refrigeration or some form of regional block is more to be blamed than the spinal itself.

The third case is somewhat more complex.

H.R.W. a 29 year old male law student, and a relative of one of the surgeons was given a spinal anesthetic for laparotomy for a perforated viscus. A perforated appendix was removed but during the procedure the spinal anesthesia was supplemented at first with pentothal ® and later with inhalation agents. As the abdominal closure was being completed, cardiac arrest occurred. Resuscitation was accomplished after the heart had been stopped approximately 4-5 minutes. Residuals of cerebral anoxia were present for several days in the form of convulsions, animal-like cries, etc. He then proceeded to make an otherwise uneventful recovery. This case could certainly not be blamed entirely on the spinal. Inhalation anesthesia and pentothal were also employed.

The discussion of this case is difficult since such a multiplicity of agents and technics were employed. It is established that a period of respiratory obstruction and respiratory depression occurred during the general anesthesia. It is reasonable to suppose that this with or without the spinal could be sufficient to have produced the cardiac arrest.

The remaining 5 cases represent conditions which are frequently blamed as complications of spinal anesthesia. When they were carefully analyzed it was found that they either existed prior to anesthesia and were not aggravated thereby, or that they were completely unrelated to anesthesia. These five cases are probably the most important of the entire group of cases. These cases are representative of the type of sequelae which are so often blamed on spinal both by laymen and professional people. In truth the administration of spinal anesthesia probably was a purely incidental thing and had nothing to do with the patient's neurological condition, yet it is cases of exactly this nature which are frequently the subjects of malpractice lawsuits.

These five cases will be discussed individually.

1. W.K. a 50 year old male had had a diagnosis of demyelination of the spinal cord and peripheral nerves on a vitamin B deficiency basis established. 3 days later before the report was in the patient's chart, he was given continuous spinal anesthesia for biliary tract exploration. Post-operative course was completely uneventful. Had he suffered further progress in his disease it would have been difficult to disprove

the effect of the anesthesia in aggravating it. The choice of spinal anesthesia in cases of this kind is condemned because it is probable that the disease will progress and also that the anesthetic agent may actually do harm.

2. D.L. was given a spinal anesthetic for repair of right inguinal hernia. At that time serology was not recorded in the chart. He was readmitted 18 months later with an apparent cerebrovascular accident. Examination revealed lentic taboparesis. This was not an anesthetic complication, but it emphasizes the importance of careful pre-anesthetic study of all patients. Since any exacerbation of his condition might readily have been blamed on the anesthesia. Here again the choice of anesthesia was a poor one. Any progress of the disease could be blamed on the anesthetic agent.

3. C.E.H. was readmitted. Abstract of history at that time is as follows: "Weakness of lower extremities for 6 months. Shortly before onset of weakness patient had a bilateral saphenous ligation and stripping under spinal." However, when the chart of the previous admission was closely scrutinized the complaint of "weakness in legs" was revealed in the initial history prior to administration of the spinal. Neurological examination on the day prior to operation diagnosed "quadriceps weakness, disuse" and cleared him for operation. It was an error of judgement to have given this patient a spinal since any aggravation may conceivably have been blamed on anesthesia.

4. A.H.H. a 55 year old male had repair of sliding right inguinal hernia under spinal anesthesia. He was discharged after an uneventful postoperative course. He was readmitted one month later with a history of having had a convulsion while unloading a truck that afternoon. There is confusion as to whether he convulsed, then fell and struck his head; or whether he fell, striking his head and then had a convulsion. The patient had a generalized epileptiform seizure while in the hospital admitting room. A diagnosis of post-traumatic epilepsy was made. He had no further episodes during his stay in the hospital.

This case is difficult to analyze because of paucity of information. Since no witnesses were present at the time of his injury one cannot say whether there is any basis at all for assuming that this is anything more than concussion with subsequent epileptiform attack. Assuming that the seizure occurred prior to the injury, it is still rather difficult to connect this with an uncomplicated spinal anesthesia more than a month previously and with no symptoms during the intervening time.

5. J.W.O'N. a 36 year old male had a gastric resection for duodenal ulcer under continuous spinal anesthesia. He had an uneventful recovery. 18 months later he was readmitted with complaints of dizziness, difficulty in walking and weakness of left leg for one year. He had loss of sexual power for 9 months. There was no blurring of vision. He was given a diagnosis of multiple sclerosis. This has been confirmed on subsequent admissions. Had the neurologic

workup been less careful, this could easily have been blamed on the anesthesia.

The five cases reported immediately above represent some of the problems an investigator is faced with in deciding whether or not an alleged sequela is truly related to the fact that a spinal anesthetic was administered. In the first 3 cases thorough investigation showed the conditions to ante-date the administration of the spinal anesthetic. In the remaining two it is believed that the administration of a spinal anesthetic was purely coincidental and had nothing to do with the subsequent neurologic disorder.

#### COMMENT

It is conceded that errors of judgment may have accounted for two of the 3 cardiac arrests. These patients were moribund preoperatively and probably should not have been subjected to any form of anesthesia other than refrigeration.

In justification of what was done, however, it must be pointed out that any delay in operating on these two would have resulted inevitably in death. The patients were both given little or no chance for survival and desperate efforts were made to salvage them. These efforts failed, but that does not per se indict the technic of management.

Post-spinal headaches of less than 1 week's duration were deliberately excluded from the study as they are not considered by the writers as major neurologic sequelae.

Headaches of less than one week's duration are self limiting. Diverse treatments are promulgated and have varying degrees of success. Since the condition is self-limiting and varies so markedly in duration it is difficult to evaluate treatment results.

The technic of administration of spinal anesthesia may be a significant factor in the low morbidity. Careful and vigorous control of sterility is a watchword in this institution.

All spinal trays are double thickness wrapped and autoclaved. Sets are re-sterilized after a maximum of one week shelf storage.

Nothing is used where there is any doubt as to its sterility. Any questionable material is discarded.

Nothing is injected into a patient's back unless it has been taken from a freshly opened sterilized ampoule. Ampoules are sterilized by immersion for a minimum of 24 hours in a

deeply red colored solution (tincture zephiran ® 1:1000). Autoclaving is not done since some drugs deteriorate under the process. The red color is more readily noticed than is blue or green when it enters an ampoule. The red color is important in that it materially assists in detecting contaminated or faulty ampoules. An ampoule may absorb the red dye even though no evidence of leak may otherwise be detectable. Any doubtful ampoules are discarded. Those showing signs of color in the solution or any particulate matter are not used. Even crystals in solutions of pontocaine ® which have been declared by some to be harmless, are not used. When in doubt we err on the side of caution.

The back is shaved when necessary. The skin is prepared with tincture of Zephiran® prior to any injections. Gowns are not worn and hands are not scrubbed, but sterile gloves are worn and great care is taken not to contaminate them. Skin sterilizing solutions are never placed inside the spinal trays for fear of contaminating the needles, etc. with them. The 1% novocaine ® used for skin wheals is removed from sterile 1 cc. ampoules rather than from cheaper but less safe bulk bottles.

Rigid rules are followed as to concentrations of drugs injected. Only sterile, individual dose ampoule medications are employed for spinal anesthesia. Pontocaine®, Novocaine®, Nupercaine® are all used. When epinephrine is added to a spinal anesthetic it is removed from a sterilized 1 cc. ampoule, not from a stock bottle. The 10% dextrose used for dilution and weighting is used only in sterilized 3 cc ampoules prepared especially for spinal anesthesia. The recommended safe dosages and concentrations are never exceeded.

We have been "guilty" repeatedly of using vasopressors such as epinephrine in our anesthetic solutions and have almost routinely used dextrose to increase baricity. We have also used continuous spinal technics. We have seen no complications that we can attribute to these procedures.

It cannot be determined at this point which are the important factors in the technic. But it is felt that any technic which did not employ at least these basic precautions would border on carelessness.

## SUMMARY & CONCLUSIONS

A four year consecutive series consisting of 10,166 spinal anesthetics administered during the years 1948-51 inclusive, was studied for incidence of neurological complications. 13 such complications falling into 5 general categories, were found. Four cerebro-vascular accidents were found. Three patients suffered cardiac arrest. Three had persistent headaches of one week or more duration. Two developed chronic backache, and one had a benign aseptic meningitis.

The findings represent the experience of a group of average training in a reasonably well

conducted hospital, using careful technics. No attempt is made to draw any conclusions from this data. It is felt however, that the neurologic sequelae of spinal anesthesia are not of such magnitude as to warrant the indictments of this anesthetic technic which have been made by those who are opposed to its use, provided results similar to those reported above are obtained. If this investigation had shown more numerous complications or more serious ones, this conclusion would not have been drawn.

It has been our experience that the morbidity and mortality with the spinal anesthesia technic compares favorably with those using other technics of anesthesia.

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## WHAT SHALL WE TELL THE PATIENT?

Out of these considerations arises another question, which every practicing physician must face repeatedly and which always requires an answer: Shall he or shall he not tell the patient who is fatally ill that he is going to die? This is a much discussed question to which there is no categorical answer. The doctor must make a special and, hopefully, an appropriate decision in every case. Probably the demoralized and apprehensive person, desperately clinging to a hope of life, should usually be allowed to delude himself. And yet it appears to be the experience of most physicians that the majority of patients

who have been fairly sound and well adjusted throughout their lives, accept the fact of impending death with calmness and often with apparent relief. When all uncertainty is cleared away, all suspicion of deception and camouflage on the part of the doctor and the family are removed, it seems to be the rule that the patient appears relatively content with the verdict and asks only for as much relief of suffering as can be accorded to him. And in the eyes of the attending physician, as he sees his patient thus courageously approach the abyss, there is a certain glory, a certain inspiring grandeur that he will not forget. *Where Lead the Paths of Glory. Editorial. New England J. Med., Oct. 1, 1953.*

# Role of Radical Neck Dissection in Head and Neck Cancer

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Accurate documentation of basic scientific effort constitutes the usual background for progress in the control of any disease. The critical data which encourage clinicians to pursue a specific course of action may vary in complexity but their potential as successful stimuli is heightened by completeness as well as by accuracy. In the field of head and neck cancer, excluding that of the eye and brain, impetus has developed during the last decade for more comprehensive and better correlated studies covering the natural biologic history of these malignancies. It may seem self-evident that a firm working knowledge of the natural course of the disease (more than merely its pathogenesis) is a prime requisite for clinical progress but often in the past such information has been inadequate. In recent years detailed chronologic analysis of patients qualifying as "therapeutic failures" has produced information which has done much to stimulate improvement in prognosis as well as in the eradication of head and neck cancer. Following are but a few of the many helpful observations gleaned from such investigation:

1. Oral malignancies may be multicentric in origin.
2. Predictable therapeutic response can be expected from a lesion in a given site and of a given histological grade of malignancy.
3. Predictable metastases and complications follow the inadequately treated primary carcinoma.
4. Recurrence in the primary site produces an increased incidence of regional lymph node metastases and a reduced number of cures.
5. In the absence of hematogenous spread control of lymphatic metastases is mandatory for cure.

---

Paper presented at the Postgraduate Conference of the Illinois State Medical Society, November 20, 1952, Peoria, Illinois.

From the Department of Surgery, Northwestern University Medical School and Passavant Memorial Hospital.

6. Radical neck dissection is the more efficient method for eradication of nodal metastases when incorporated in the primary plan of treatment.

Failure of potentially successful cancer therapy is noted by recurrence in the primary site or persistence in the regional lymph nodes. It is conjectured that clinical arrest could have been achieved had a more enthusiastic effort been made to eliminate the primary tumor or more completely to eradicate the regional lymph nodes. Although recurrence in the primary site is of major concern it is our purpose to stress the need for better control of the regional metastases in order to improve long term results.

Experience in the use of radiotherapeutic methods has led to almost universal acceptance of the concept that a carcinoma often may be eradicated in its primary site by irradiation while the regional lymph node metastases will present a distressing degree of radioresistance. Almost as a corollary we now appreciate the well substantiated clinical observation that surgical excision is superior to radiotherapy in the eradication of localized lymph node metastases. For this reason there has evolved a growing sentiment regarding the surgeon's responsibility for eradication of cancer in lymph nodes.<sup>1</sup>

## MECHANISM OF LYMPHATIC METASTASIS

Cancer cells enter lymphatic vessels by direct invasion and are carried as emboli to the nearest node where growth continues. The node may become completely replaced and thus the flow of lymph through it becomes blocked. Collateral lymph drainage permits other nearby nodes to receive tumor emboli so that extension of the disease readily occurs. How long an interval is required for these tumor emboli to travel from the primary lesion to a particular node remains a matter of conjecture, and apparently this is quite dependent upon the size of the cell or cell cluster as well as upon the velocity of the lymph stream in a given area. After a sufficiently large

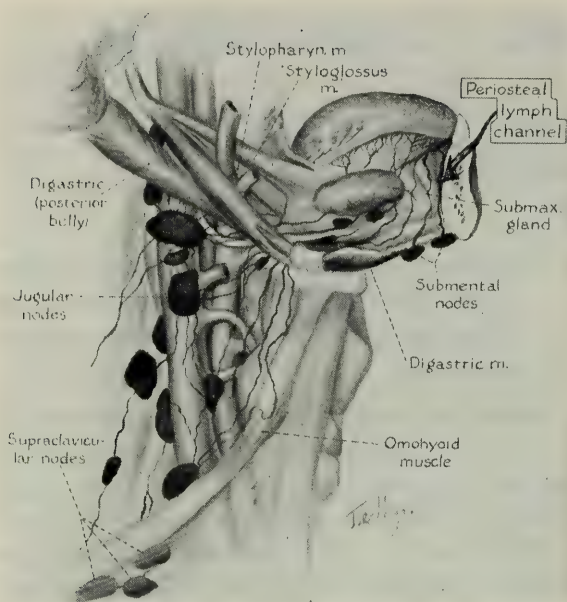


Figure 1

number of nodes in a given area have become blocked the lymphatic spread becomes less predictable. This unrestrained type of manifestation gives credence to Handley's belief that lymphatic permeation is the usual method of spread. While this mechanism obviously operates, it is found only in the later stages or in an early phase of a highly malignant growth.

While there is no question that the metastatic tumor grows well within lymph nodes we also should recall that the nodes act as mechanical barriers against distant dissemination. (Figure 1). Malignancies arising in the head and neck area demonstrate this fact very well. Large autopsy series reveal that only from 15 to 20 percent of such patients die with metastases below the clavicle.<sup>3,4</sup> In the absence of obvious hematogenous spread it is evident that the direct lethal effects of local and regional neck manifestations of these neoplasms are considerable. The anatomical classification for such tumors is as follows:

- A. Skin of head and neck.
- B. Lip and oral cavity
- C. Hypopharynx and larynx
- D. Paranasal sinuses and nose
- E. Salivary glands
- F. Thyroid gland

At first glance one might conclude that these categories contain unrelated lesions, but the common denominator is their inherent tendency

to produce cervical lymph node metastases. Because these tumors spread to the nodes by predictable embolization, dissociation of treatment of the primary from that of the metastases has become an accepted practice. This is based on the premise that complete control of the primary will have been accomplished before the nodes are excised. When this plan is successful there is a salutary preservation of normal intervening tissue.

Dissociated or discontinuous therapy may be a compromise of the current concept of what constitutes a "good cancer operation" as exemplified by the modern radical mastectomy or abdomino-perineal resection of the rectum. Eradication of the primary is not achieved in all patients so that local growth may continue. In addition, the biologic activity of some neoplasms may produce an unusually high percentage of early lymph node metastases. Under such circumstances of extensive regional involvement more enthusiastic in-continuity types of excisional therapy have been introduced. Removal of the lower gingiva combined with homolateral radical neck dissection is a basic example. This application of the classical principle of dissection and excision of the primary and related nodal metastases in continuity already has shown much promise.<sup>5</sup> In an effort to clarify the appropriate use of these two general types of therapy as we appreciate it today each of the six head and neck classifications should be explained individually.

#### SKIN

Malignant lesions of the skin of the head and neck are easily accessible for diagnosis and treatment. While these neoplasms present an excellent opportunity for cure it is not uncommon to find examples of lingering disease because of inadequate primary treatment. In general, the lymph node involvement is a very late manifestation, except in the malignant melanomas. The following classification includes the usual histo-pathological variants:

1. Basal cell carcinoma

This is characteristically slow growing unless stimulated by inadequate therapy or extension into the mucous membrane of the nose or conjunctiva. Lymph node metastases are very rare and then usually when there is a

mixture of basal and squamous cell elements in the primary.

## 2. Squamous cell carcinoma

A more vigorous tumor with infiltration and fixation of surrounding tissue, the activity varying with the degree of histological differentiation. A small but definite percentage of them produce both local and distant metastases.

## 3. Adenocystic basal cell carcinoma

Somewhat like the regular basal cell lesions but they grow more rapidly and at times metastasize to regional nodes.

## 4. Malignant melanoma

This constitutes by far the most vicious of all surface tumors. It always should be borne in mind that 85 percent of them arise in previously benign pigmented nevi and that 25 percent of all occur in the region of the head and neck. We recognize those with ovoid cells as being most malignant while those composed of spindle shaped cells are less likely to metastasize and if they do metastasize tend to remain localized for longer periods of time.

*Treatment.*—For lesions in the first three classifications the therapy for the primary may be irradiation or surgery so long as the attempt at eradication encompasses an area of sufficient width and depth. Lymph node metastases occur rarely, usually in long standing cases or in those previously inadequately treated. If the squamous cell carcinoma is larger than two centimeters at least 15 percent of the patients will develop positive cervical nodes and will require neck dissection.

The treatment of malignant melanoma is strictly surgical. This entails wide and deep excision, closure of the wound often being accomplished only by means of skin graft. When the nodes obviously are involved the principle of dissection and excision in continuity should be put into practice wherever it is mechanically and anatomically possible. When the nodes are not enlarged the dissection should be done as a separate procedure. Clinical appraisal of palpable lymph nodes is probably more fallible in malignant melanoma than in other malignancies. Pack reported 50 percent involvement in patients who had undergone so-called prophylactic dissection.<sup>6</sup> Lymph node metastasis is so common that we advise routine dissection for all patients

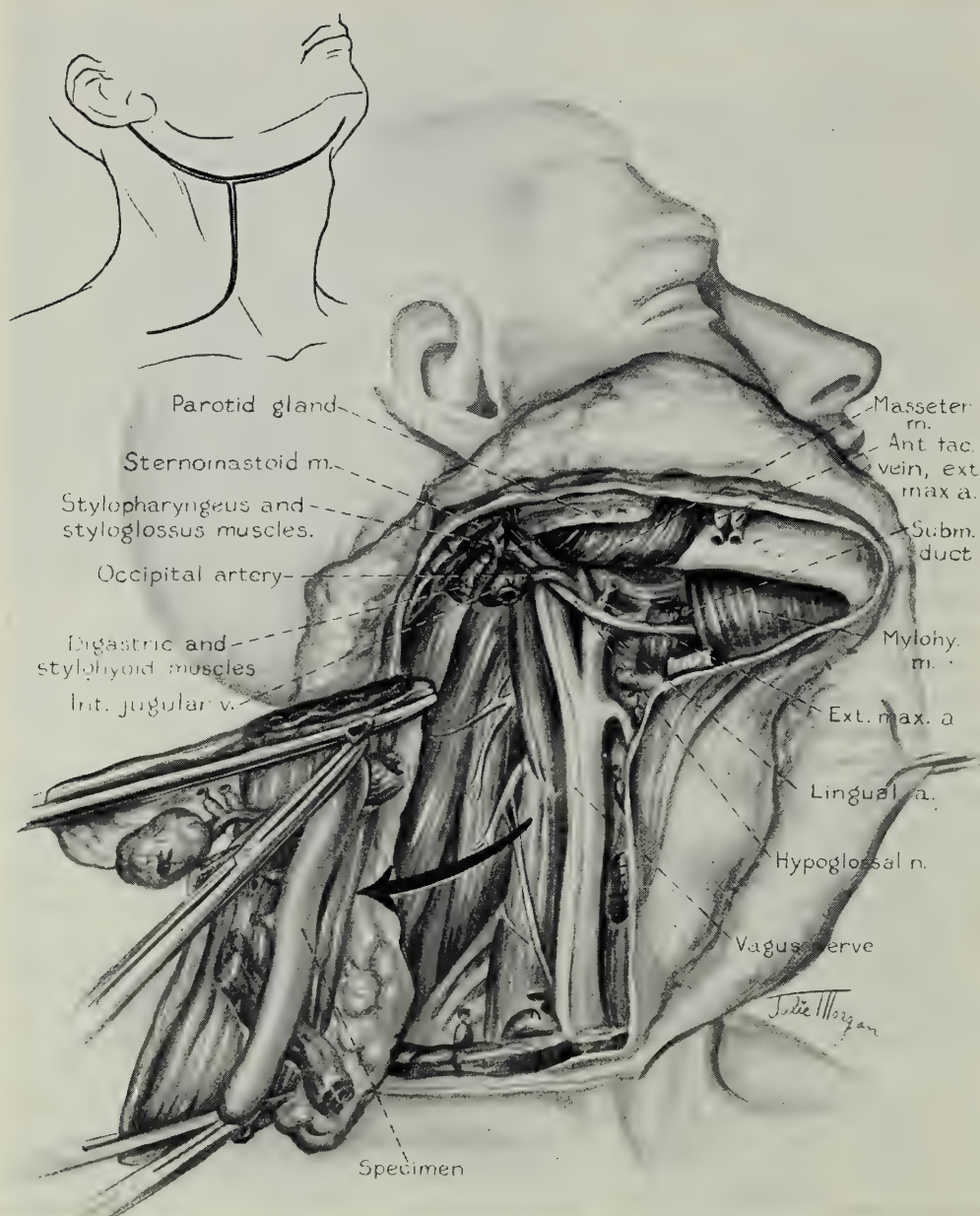
except children and negroes who show a low incidence of metastases. When the nodes are not enlarged the procedure can be discontinuous, but when the involvement is more evident the in-continuity procedure is more logical in order to encompass any possible tumor cells whose lymphatic spread has been made irregular by proximal obstruction.

## LIP AND ORAL CAVITY

Cancer of the oral cavity comprises about 5 percent of all human cancer. It is a disease essentially of middle and old age, males being affected about five times as frequently as females. About three-fourths of these lesions are well differentiated, the more anaplastic lesions often being found in the area of the tonsil and base of the tongue. Nine-tenths of these malignancies are squamous cell carcinomas. Although the oral cavity produces at least ten separate clinical types our condensed classification is based on a consideration of the various anatomical sites according to the way in which they lend themselves to therapy.

*Lip.*—Carcinoma of the lip tends to be a local disease in 80 percent of the patients, chiefly because therapy is sought relatively early. Control of the primary lesion has been achieved equally well by both radiation and surgery in small lesions. Radiation failure is more likely to occur when the tumor approaches 3 centimeters in size and deeply invades the underlying muscle. Wide excision and plastic repair will produce very satisfactory results even after radiation failure. Repeat radiotherapy usually is avoided because the tumor bed and surrounding tissues become so devitalized that healing is seriously impaired.

After the local area has healed the neck nodes must be reappraised. Because lip cancer often is found in an early phase, routine neck dissection is advised for only a few patients. About 20 percent of these patients when first seen will present enlarged cervical nodes and automatically become candidates for bilateral supraomohyoid dissection. When positive nodes are found a more complete jugular dissection is done on the homolateral side. Of the remaining 80 percent about ten percent eventually will develop cervical metastases. Since over half of these who later develop positive nodes can be salvaged by delayed dissection a large number



**Figure 2**

of supposedly "unnecessary" operations should be prevented by adoption of an expectant attitude. On the other hand, an increased incidence of positive nodes will be found when the primary is over 2 centimeters in size, is of long duration, or is of short duration but has shown rapid growth, is anaplastic in type or has been inadequately treated. For these patients neck dissection may be quite justified, especially when adequate follow-up will be difficult. With the morbidity and mortality of block dissection now reduced to a bare minimum we are inclined to try to increase the cure rate through the use of adequate neck dissection in as many patients

as it may seem justified. (Figure 2) This does not mean, however, routine neck dissection for all.

*Buccal Mucosa.*—Buccal cancer may be more bulky and papillary, and it tends to ulcerate late. There is a verrucous type which has local invasive qualities but less tendency toward lymph node involvement. The entire group produces cervical metastases in about 40 percent of the cases. Radiation or wide excision produces adequate results depending upon the local environment and type of lesion. These lesions also may be multicentric in origin. If the lesion is extensive, a full cheek resection with replacement by lined

pedicle flap may be necessary. The general indications for neck dissection are essentially the same as that for the lip but the number will be higher. When the adjoining surfaces of the lower gingiva becomes involved the perimandibular lymphatics are prone to contain tumor cells. The procedure of choice then becomes an incontinuity excision consisting of radical neck dissection with hemimandibulectomy and excision of the cheek. Repair of the defect should be done immediately by means of a previously prepared flap.

*Upper Gingiva and Hard Palate.*—A high degree of vacillation has characterized the prevalent attitude toward treatment of carcinoma of the upper gingiva and hard palate. Surgery, radiation and electrocautery or some combination of these agents have been used, and for the most part only as palliative measures. Wide surgical excision, employing an extraoral approach by reflecting the cheek, undoubtedly will produce the best results with a minimum of difficulty to the patient. About 25 to 40 percent of these patients will present cervical lymph node metastases during the early phase of the disease. When it is felt that the primary has been controlled, neck dissection should be done if there is evidence of involvement. There is a possibility of bilateral metastases and in such case the procedure should be done in stages with preservation of the second jugular vein if manometric readings suggest the need.

*Lower Gingiva.*—This type of cancer formerly was regarded as being relatively benign, but continued experience shows this not to be the case. Local extension is so common that the cheek, floor of the mouth and the underlying bone may be invaded in two out of three patients. In some series the tendency toward cervical lymph node metastases has been reported as high as 65 percent. Radiation still is used for the primary but with only small degrees of success. About 80 percent of these lesions either are not controlled by the usual local irradiation or when first seen manifest some degree of extension into adjoining soft tissue. Mattick and Meehan recently reported 101 cases of cancer of the gingiva treated entirely with radiation.<sup>7</sup> No patient with either node or bone involvement was cured by this method. From such observations as this it follows that both the primary and the obvious

nodal metastases must be excised in order to obtain better results. It is now our practice to do the combined procedure of hemimandibulectomy and associated radical neck dissection for this lesion. Functional and cosmetic results have been quite satisfactory.<sup>5</sup>

*Anterior Two-thirds of the Tongue and Floor of the Mouth.*—These lesions lend themselves well to consideration as a single clinical entity not only because of the great similarity in their embryological and anatomical relationships but also because of their similarity in tumor pathogenesis and treatment. Squamous cell carcinomas of these areas metastasize freely to the regional cervical nodes, the incidence being about 65 percent with 15 percent bilateral. Unlike many other oral cancers these lesions are known to metastasize to distant viscera when uncontrolled.

Radiation still is the most popular first choice in treatment of the primary, but ability completely to sterilize the neoplastic process in all instances is a goal not as yet achieved. For this reason wide surgical excision is performed by many clinicians. Ward and Hendrick, who believe in combining the two agents, found 21 percent of patients to have residual cancer in surgically excised specimens following appropriate irradiation.<sup>8</sup> This combined approach to the primary might constitute an important factor in increasing the incidence of completely controlled primary lesions.

Much has been written regarding the routine dissections of cervical nodes after the primary has been eradicated. The greatest number of patients would be benefited if bilateral complete neck dissections were done in stages. A homolateral complete dissection is performed first. If the nodes are found to be negative the opposite side is not operated upon unless the lesion approached the midline. If the nodes are positive, the contralateral dissection is done within a few weeks and the jugular vein is left in place if manometric studies suggest the need. Our position seems to be justified by the recent report of Lyall and Schetlin who found no crossed metastases in those cases in which homolateral nodes were not positive.<sup>9</sup>

In those patients in whom the submaxillary and sub-digastric nodes are grossly involved a further problem exists. The resultant alteration

of lymph flow makes metastatic embolization less predictable and encourages permeation spread. Such spread is further possible when the growth approaches the mandible or when an obvious post-radiation recurrence takes place before the nodes have been removed. The most practical method of solving this problem is to excise the primary and the nodes in continuity with all the intervening lymphatics. The second side is done at a later date in the ideal cases.

*Soft Palate, Tonsil and Posterior Third of the Tongue.*—Malignancies arising from these areas are characterized by powers of local invasion with great tendency to metastasize to the homolateral cervical nodes. The patient often will present a palpable enlarged jugular node when first examined. Although varying degrees of differentiation occur, these lesions are treated almost routinely by radiation. The recurrence rate is high and the large amount of radiation necessary to sterilize these lesions produces a high incidence of necrosis. For these reasons there is a growing tendency to follow radiation with in-continuity type of excision including the regional nodes. Skin flaps are required for closure. In some of the tonsil lesions the discontinuous approach may suffice. Despite the fact that the high jugular nodes will receive a good deal of radiation during this treatment, it is a matter of considerable interest that the lymph node metastases often remain evident, thus making neck dissection mandatory at a later date.

#### HYPOPHARYNX AND LARYNX

Widespread differences of opinion exist concerning what constitutes correct therapy for carcinoma of the larynx. Some of the confusion noted in the literature arises from variations in terminology. Confusion of the issues involved arises in part from the emotional reaction of the clinician who is so unduly anxious to preserve the voice that he fails to appreciate or is unwilling to consider the malignant aspect of the disease. Recent history leads the unbiased observer to conclude that there is a trend in the direction of a more vigorous surgical approach to control of laryngeal cancer, but as in other neoplastic therapy the eventual standardization of procedure will be a time consuming and evolutionary process. Each medical community is reluctant to accept radical surgical methods until it has become clear that the use of more conservative

means has led to a significant number of treatment failures.

The time-honored division of extrinsic and intrinsic laryngeal carcinoma has much in its favor when one considers the matter of regional lymph node metastases. The intrinsic (cordal or glottic) lesion tends to develop as a local process with extension into neighboring structures but with only a 15 percent incidence of spread to cervical lymph nodes. While radiation is of value in small lesions, complete laryngectomy is proving to be far more effective. Regional node dissection may be reserved for the few who develop metastases at a later date, or it may be performed in continuity at the time of the primary surgery where nodal involvement is evident. It must be remembered that this spread may include not only the jugular chain but also the deep anterior cervical nodes in relation to the anterior and lateral surface of the larynx and esophagus. For this reason the in-continuity procedure is highly recommended when indicated.

In any discussion of extrinsic carcinoma of the larynx one immediately is confronted by the difficult problem of defining the boundary between the larynx and the hypopharynx. Some authors content themselves with the term pharyngolarynx and permit consideration of borderline lesions. From the practical standpoint this classification has been useful because all such lesions in the past have been treated by means of radiation. Regional lymph node involvement varies from 60 to 75 percent depending upon the stage of development. Cure rates have been depressingly low (from 6 to 15 percent five year clinical arrests).<sup>10</sup> When the primary lesion was believed to be radiotherapeutically controlled, radical neck dissections have been done. Where metastases were limited to one side this has proven to be of value in a selected series. Bilateral nodal involvement on admission may be as high as 20 percent, and until recent years has been considered a contraindication to surgery. We now realize that bilateral neck dissection is a logical and acceptable procedure, but it has taken time for this to be appreciated. The most encouraging report to date comes from Martin who recently reported his extension of surgical attack to include a bilateral neck dissection with in-continuity panlaryngectomy and/or hypopharyngectomy. He presented a suf-

ficiently large number of patients to suggest that the morbidity was not great and that the three and five year clinical arrest rates were much improved over his own irradiation series from previous decades.<sup>9</sup>

#### PARANASAL SINUSES

Malignancies of the paranasal sinuses and nasal mucosa can be discussed under one heading because they arise from similar strata. The individual lesions can be listed as follows:

1. Carcinoma of the antrum
2. Carcinoma of the ethmoid sinuses
3. Carcinoma of the sphenoid sinuses
4. Carcinoma of the nasal mucous membrane
5. Carcinoma of the frontal sinuses

The general plan of therapeutic approach in the past has been that of irradiation in the form of radium and X-ray. Following the experience of Ward it seems logical to combine electro-surgical excision with radium implants in order to accomplish a more radical approach. Wide local extension always is found so that primary closure of the defect may not be practical. In the absence of local recurrence a pedicle flap can be used to a great advantage. A dental prosthesis completes the reconstruction.

In regard to cervical nodes our attitude has been entirely expectant. Dissections are indicated only when palpable nodes appear and uniformly this is late in the course of these malignancies.

#### SALIVARY GLANDS

The great majority of tumors involving the parotid, submaxillary, and sublingual salivary glands are mixed tumors, most of them benign, with about 15 percent being malignant. Malignant transformation of mixed tumors is a recognized fact but it frequently is very difficult to differentiate between benign tumors and those that have become malignant. If incompletely removed they recur locally but seldom metastasize as mixed tumors. Treatment always is surgical excision.

Malignant tumors of salivary tissue can be thought of as either primary or secondary, the latter being those which arise in mixed tumors or adenomas. These tumors grow more rapidly and metastasize to the regional nodes as well as to the lungs and osseous system. In the presence of microscopic proof of carcinoma the procedure of choice is wide excision and neck dissection in continuity. When the parotid is involved the

submaxillary triangle must be included in the excision, but in the occasional instance of malignant submaxillary tumor the radical neck dissection need not include the parotid region.

Aberrant salivary tissue tumors found in the palate also require wide surgical excision, but here the problem of neck dissection is more elective. The cervical nodes require close examination, and dissection can be carried out when they become involved, if ever.

#### THYROID

Variation in clinical behavior of thyroid cancer can be well correlated with histological characteristics to such an extent that at present the natural history of the various types of thyroid cancer is much better understood. Although there are exceptions that add confusion to the prognostic efforts of the most astute clinician the following classification will be found helpful.

1. Adenocarcinoma arising in an adenoma

This is frequently a pathologic diagnosis without any substantiating clinical evidence. A few develop late metastases to regional nodes.

2. Papillary adenocarcinoma

A true malignancy not necessarily originating in an adenoma, affects one lobe and, while it is slow growing, it involves regional lymph nodes in from 60 to 75 percent of the cases.

3. Solid adenocarcinomas

The second most common form of thyroid cancer, possesses a high degree of malignancy and may arise from multiple sites. At least half of the patients will present involved nodes at the time of the first visit.

4. Alveolar adenocarcinoma

This is a smaller group with a more malignant course, greater invasiveness and a tendency to involve lymph nodes earlier.

5. Hurthle cell adenocarcinoma

This is somewhat similar to the alveolar form with a distinct acidophilic cast to the cytoplasm of the acinar cells. May be encapsulated but tends to recur after resection. While it is local, invasiveness is a major problem, and 40 percent will have involved nodes.

6. Giant cell carcinoma

This is the most malignant of thyroid tumors, if not of the whole body. The average duration of life from diagnosis to death is about five months.

Although the regional nodes have not been

overly emphasized, their involvement with metastases certainly is not a new realization. Reports issued between 1935 and 1950 reveal an average incidence of positive nodes of about 38 percent. Among the more recent studies, Ward and Hendrick report 35 percent of 112 patients to present node involvement. In their series 85 percent (17 out of 20) of papillary adenocarcinomas had positive nodes, all on the homolateral side.<sup>12</sup>

*Treatment.*—After microscopic diagnosis of malignancy has been obtained, it is our practice to perform a complete thyroidectomy in continuity with a homolateral radical neck dissection. The submaxillary triangle need not be included. The anterior strap muscles are removed but in selected instances the sternocleidomastoid can be preserved.

In cancer of the thyroid, operability depends upon the extent of the local lesion as well as on the existence of bilateral and distant metastases. While bilateral neck dissection and complete thyroidectomy is of value for a selected few, profound surgical judgment is required in evaluating such patients. Consideration of the histological characteristics as well as of the local findings will aid in selection of the most appropriate method of handling each problem. Although the use of radioactive iodine still is investigative in character, it should be recalled that it is of value only in those with complete thyroidectomies and whose tumors show an avidity for iodine.

#### SUMMARY

Full knowledge of the natural biologic history of any neoplasm is a prime requisite before adequate plans for curative therapy can be outlined. Such knowledge resolves the problem of successful eradication of cancer into a consideration of the primary focus and of the predictable spread to regional lymph nodes. This concept applies particularly to head and neck cancer because early hematogenous spread is relatively uncommon. In the absence of dis-

tant metastases, fruitful consideration can be given to the control of the local and regional biologic process with radiation or surgery as the individual problem may demand.

Since the mechanism of lymph node metastasis is primarily one of embolization to regional nodes the concept of dissociated therapy is logical under certain circumstances. Control of the primary focus and later dissection and excision of the lymph nodes is the essence of such planning. This method is used in squamous cell carcinoma of the skin, lip, buccal mucosa, tongue and floor of mouth, soft and hard palate and of the maxillary sinuses.

In contrast to this method, there is that of excision of the primary neoplasm with the regional collecting nodes in continuity. This is applicable to melanocarcinoma of the skin, carcinoma of the salivary glands, thyroid, extrinsic larynx and hypopharynx, and extensive carcinomas of the mouth. While this continuous type of excision is a massive procedure, to date considerable human salvage has been attained. 700 N. Michigan Avenue

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# Obstructions of the Lacrimal Duct

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The treatment of acquired obstruction of the lacrimal ducts has been tremendously simplified by the development of plastic tubing. Its use is to some degree a reversion to earlier forms of treatment. The instillation of silver tubes following incision of the canaliculi and dilatation with large probes was similar to present day use of plastic tubing. The metal tubes had the disadvantage of being difficult to insert properly compared to plastic and there was much more reaction. Dacryocystorrhinostomies are in most cases efficacious but they are difficult to do successfully and produce far more reaction than instillation of plastic tubes.

Because of the relative ease of insertion of these tubes they can be used in many cases where previously the cure was considered worse than the disease. Particularly in older people where tearing could not be controlled by probing and irrigation alone or where repeated treatments were necessary I have often been reluctant to subject the patient to the discomfort of the more radical dacryocystorrhinostomy or repeated probings.

My first experience with plastic tubes for this purpose was in cases with repeated attacks of purulent dacryo-cystitis. In these cases I incised the lacrimal sac and made an aperture into the nasal cavity with a drill. The tube was passed thru the inferior punctum into the sac and thru the opening into the nose, giving a modified dacryocystorrhinostomy. This procedure was not particularly satisfactory and less successful than previous types of surgery. I then started introducing the tube thru the natural bony opening into the nose. I have tried several methods of doing this and now have one that is quite successful, thanks to the work of Dr. Paul Kimball, one of our residents at St. Luke's Hospital. Dr. Kimball while in service with the navy devised a trocar with an obturator that can be passed thru the punctum into the bony canal to the nose with a minimum of trauma and effort. This can be done under local anesthesia and so

far we have had relatively little trouble forcing it thru even where there has been considerable trauma. We have just discharged a patient who was struck in the face by a railroad tie with resulting fracture of the nose and upper jaw; there was extensive distortion of the nose and face. We felt that in this case it would be impossible to pass the trocar thru the natural bony canal but we succeeded without too much trouble. It is my opinion, after this case, that in the majority of instances there will be enough of the passageway remaining to guide the point of the trocar along the right path once it is started in the bony canal; and in the average case, it is easily inserted. There is some danger of forcing the point into the orbit or antrum but this danger is decreased by using an instrument with a slight curve similar to that of a Bowman probe. The instrument Dr. Kimball devised is a modification of an antral trocar and has a curve slightly greater than that of a Bowman probe. I believe it is relatively safe. The outside diameter is 2 mm. which is comparable to a #2 Zeigler probe. This is large enough to offer excessive resistance if one is completely out of the natural passageway. We have had difficulty in passing the instrument thru the inferior punctum without tearing and slitting it which is certainly not desirable. This can be avoided to some degree by dilating the opening with large Zeigler probes. We found the ordinary punctum dilator totally inadequate for this procedure.

After the instrument has been passed into the nose and is in proper place the tip can be seen extending out from under the inferior turbinate from the opening in the inferior meatus. The obturator is then withdrawn and the tubing inserted. The end of the tube is easily seen if a nasal speculum is used provided it is in properly. It can be easily grasped with nasal forceps and drawn forward to the outside of the nose.

One of the problems encountered in this procedure was the final positioning of the tube. At first we left a portion approximately 2 centimeters long extending on the cheek and taped it down. The other end was left long enough

to tape it on the lower portion of the cheek. This kept the canal open and permitted epithelization to occur around the tube. It did not take advantage of the lumen of the tube and furthermore I believe obstructed the flow of tears. Our next modification was to insert the tube in the same position and cut openings in that portion in the canaliculus and sac. This produced some passage of tears thru the tube but apparently the openings quickly filled with mucus plugs and did not function adequately. We also tried leaving the upper end even with the opening in the punctum and also just inside it. This worked better than leaving it all the way out and gave adequate drainage of tears. However, in all these methods there was considerable irritation of the lids and in some cases the end of the tube irritated the eyeball. In no case was this complication serious but it was annoying.

Our next step in positioning the tube was the one I believe is most satisfactory and probably the one we will continue using. Dr. Robert Carlisle, our other resident at St. Luke's, suggested drawing the tube into the canal so that the upper end was in the upper portion of the sac. I believe this is satisfactory in all cases where fluid forced into one canaliculus will flow back out of the other. This indicates that there is no obstruction of the canaliculi before their junction with each other. Where there is obstruction of the inferior canaliculus the tube must be left at least partially in it to prevent recurrence of fibrous obstruction above the end of the tube. In most cases of acquired obstruction which I have seen other than those where there were lacerations of the eyelid there has been a free flow of fluid from one canaliculus to the other. This indicates that in the majority of cases they join together before entering the sac. Duke Elder in his first volume makes reference to the canaliculi entering the sac separately as well as being joined together before entering.

After trying the procedures already mentioned and others, we have evolved a technic which is fairly satisfactory. The trocar is inserted thru the superior canaliculus after it has been well dilated with Zeigler probes, and passed into the nose. A black silk suture is inserted in the upper end of the tube and it is passed thru the trocar into the nasal cavity. The tube is drawn downward to a point where fluid instilled in the

inferior punctum runs freely out of the tube. By means of the silk suture at the upper end the tube can be drawn upward so that the proper position can be obtained. The lower end protrudes beyond the edge of the nose just far enough to grasp easily and not far enough to be bothersome. Once the tube is properly positioned the silk is anchored in place on the forehead by means of adhesive. Irrigation can be started on the following day and the tube repositioned so that drainage occurs from both canaliculi by pulling the tube up or down as the occasion requires.

The next problem confronting us is one that I cannot definitely answer. How long the tube should be left in place? Dr. Everett Veirs in an article in the January 1952 issue of the Archives of Ophthalmology states that in stenosis of the nasolacrimal duct one week seems long enough for the tube to remain in place. He further states that in cases of stenosis of the lower canaliculus it should be left in from 60 to 90 days. In complete obstruction of the canaliculi he suggests a longer period even up to a year. Henderson reported a case where he left the tube 45 days. We have left tubes in place from a week to a month and I am inclined to believe that the longer they are left the better and more permanent the cure. My feeling is that with the procedure above outlined the tube can be kept anchored in place for two weeks. The anchoring suture can then be removed and the tube cut off rather short in the nose and be left indefinitely. It will usually come out spontaneously either by being blown out or protruding enough so that the patient can draw it out. There is in my opinion little danger of aspiration of the tube which is the only contra-indication that I can think of to leaving it free in the sac and nasolacrimal duct.

We have been irrigating the duct daily after instillation of the tube. There is usually considerable accumulation of mucopurulent secretion around the lower end of the tube blocking it and keeping this clear facilitates immediate drainage. Furthermore, daily drainage insures proper positioning of the tube. After a few days, depending upon the progress of the condition the irrigations can be stopped, and the patient instructed to use hydraulic pressure by rolling the tip of the finger from the inner angle of the eye towards the nose as we do in infants with obstruction. This seems to be sufficient in

most cases to remove any mucus plug that may block the canal. The patient can move the tube up or down easily to facilitate drainage until it is cut off short in the nose, and to some degree even then. It is my feeling that monthly irrigations should be kept up for several months. This not only cleans out the duct and sac but enables the physician to determine any tendency toward recurrence of the obstruction and to start more intensive treatment before complete obstruction recurs. In a certain number of cases there is bound to be recurrence and it will be necessary to reinsert a tube. This should be easier than the primary insertion and certainly will be easier if the obstruction is not permitted to become complete.

In traumatic obstruction of the canaliculi plastic tubing is ideal. I have used it in two instances where the inferior one was completely obstructed and the superior patent. In both, fluid injected into the superior punctum flowed freely into the nose. In the first case I could find no trace of an opening in the lid margin and was unable to locate a passageway in the lid when I incised it. There were no other anomalies and as complete absence of the canaliculus is rare except in the presence of other developmental deformities I imagine there was a canal present that I could not find. After trying vainly to locate the canaliculus I passed an 18 gauge needle thru the lid where I felt the canal should run into the sac. This passageway was then dilated with Bowman probes and a tube inserted into the sac. No effort was made to pass it down into the nasolacrimal duct. The end of the tube had to be cut short at the lid margin to prevent irritation of the eyeball with the result that I have had considerable difficulty in keeping it from healing over, and repeated dilatations have been necessary. Lacrimal drainage is good except in real cold or windy weather when the patient still has trouble. However, there is no constant wiping of the eye as she had previously.

The second case of obstruction of the canaliculus on which I have used it was a young man whose eye had been removed following a severe injury which also lacerated the lower lid severely. The canaliculus was patent for about 2 mm. so that a 14 gauge needle could be inserted thru the original canal into the sac. The superior canaliculus was partially obstructed and he had con-

stant purulent discharge and tearing. The tube was inserted thru a straight 14 gauge needle and left protruding slightly. Since he wore a prosthesis it did not produce any irritation of the eyeball and I left it in place for a month. The tearing is almost completely relieved and there is no purulent crusting such as he had before.

I have seen one case in which the inferior canaliculus was patent but covered over at the punctum by a thin membrane which appeared to be epithelial. The patient was a young soldier who gave a history of tearing from the involved eye as long back as he could remember. He denied any injury or severe inflammation of the eye. When the membrane was incised it retracted and the duct functioned normally. He was in my hospital overseas for other injuries for six weeks after this and throughout that time there was no evidence of recurrence. This latter condition is much less rare than absence of the canaliculus but is still sufficiently unusual to warrant mentioning.

Local anesthesia is adequate for inserting these tubes in most cases. Blocking of the infra-orbital nerve at the site of the infra-orbital foramen, supplemented by injection at the site of the sac, gives good anesthesia for the sac and upper portion of the passageway. 2 per cent novocaine is used and the addition of Hydase is advisable in that it facilitates the spread of the novocaine to cover a wider area. Anesthesia in the nose is produced by instillation of 2 per cent Pontocaine via spray or nasal packs. I think it is also advisable to instill .5 per cent Pontocaine in the conjunctival sac.

#### SUMMARY

I wish to emphasize the proper positioning of the tube in the lacrimal canal. If the obstruction is a stenosis either in the canaliculus or in their junction outside the sac a malposition of slight degree would defeat the procedure. In some cases the turbinate has to be forced over by the point of the instrument and considerable force may be required at the point of entering the nose. This procedure may be safely used following purulent dacryocystitis with obstruction as well as in those cases without any history of acute inflammation. Only time will tell how many of our cures are permanent but the plan offers possibilities and is relatively easy to perform.

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# The Psoriasis Problem

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The problem of psoriasis is as old as dermatology itself.

It is one of the more common skin diseases as two to eight per cent of all skin patients are psoriatics.

Little difficulty is encountered in diagnosis as the lesions are characteristic and readily recognized. Exceptions occur when the psoriatic lesions are limited to the scalp, palms, or soles; in the intertrigous form of the disease; and with solitary lichenified patches.

Even though psoriasis is amenable to clinical observation and investigation, a full understanding of its etiology and pathogenesis is lacking. Throughout the years, a number of theories have been advanced which have become increasingly complex with our extending knowledge of physiology, metabolism, endocrinology, and enzymology. The therapeutic procedures recommended are entirely empirical and, to make matters worse, the variable course of the disease renders exceedingly difficult an objective evaluation of any therapeutic agent.

We cannot be surprised, therefore, when modern physicians, who are accustomed to a scientific approach in diagnostic and therapeutic procedures, become skeptical, if not negativistic in dealing with psoriasis. As a result they often do nothing for the psoriatic, except for prescribing medicine or ointment in which the physician himself has little or no faith. For purely psychological reasons, this is an impossible situation.

It is generally agreed that the eruption represents the cutaneous manifestation of a systemic disorder. The numerous observations of a higher incidence of the disease in certain families and the influence of gestation, lactation, dietary changes, intercurrent disease, and emotional upsets yield sufficient evidence for such a concept. With this consideration as the basis for a therapeutic approach, it is self-evident that, as in any

other chronic illness, the physician's interest must not be limited to the skin lesions but should include the patient's general, physical, and mental condition. A careful history should list the patient's dietary habits, his working conditions, and his hours of rest and sleep. Every deviation from normal health should be corrected if possible.

To the patient with extensive eruptions involving large areas of the body surface, the aforementioned approach appears natural and logical but when the cutaneous involvement is limited the reasons for such a general investigation must be explained to the patient. This will present undue concern and, at the same time, make him aware of the difficult task he is assigning to his physician. In a spreading eruption, the patient then will be better prepared to meet this crisis in his social and occupational life, will be better adjusted emotionally, and will be more cooperative in following therapeutic instructions. For all these reasons, his chances for recovery will be improved.

In outlining treatment, the physician must be familiar with the potentialities and limitations of the various methods. Although there is no certain cure, the tried and well proved techniques at our command are not as ineffectual as is often asserted. I have the firm conviction that our therapeutic efforts can shorten the duration and limit the extent of the eruptive phase of the disease. Treatment is not simple, however, and a textbook knowledge of pharmacology is not sufficient to assure success. Skill in applying the various procedures can be acquired only by experience and by patient and studious observation.

The patient's cooperation is of the greatest importance. We all realize the cosmetically objectionable qualities of some of our topical preparations, but we must make clear in our own minds and impress upon the patient as well, that there is no elegant, beauty parlor cure for psoriasis. To counteract the forgetfulness or therapeutic indolence, which we observe in some patients, it is necessary for the physician to give his orders with a certain amount of uncomprom-

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mising dogmatism. This dynamic approach creates willfulness of purpose in the patient and provides the optimism so sorely lacking in the average psoriatic, often discouraged by past experience.

For topical treatment of old, established lesions, we prefer a 5 to 10 per cent ammoniated mercury ointment, chrysarobin, or Anthralin ointment in gradually increasing concentration and crude coal tar preparations, either alone or in combination with ultraviolet radiation according to Goeckerman's technique or one of its modifications. The aim of this type of therapy is the production of mild irritation of the psoriatic plaque and its surrounding apparently normal skin. Proper care must be taken to avoid excessive reactions. It is wise, therefore, to begin with low concentrations and to increase the strength gradually according to the need of the individual case. It is essential that all lesions are treated at the same time and that the treatment be continued not only until the lesions have bleached, but until the skin involved by each patch is no longer distinguishable from the surrounding normal skin.

Patients with acute exacerbations or with extensive involvement of the tegument should be confined to bed, when the physician can visit the patient often and supervise treatment but preferably, in the hospital, where the patient is relieved of his domestic responsibilities and incidental emotional stresses. In such cases, the early topical treatment should be relatively mild, consisting of colloid baths and mild lotions, liniments, or ointments until such time as the eruption passes from the acute to a more stable form. Even in the latter stage the patient should remain in bed, since the application of ointments to large areas of the body surface is almost impossible while wearing street garb. Although the high cost of hospitalization seems to render this procedure uneconomical, the results are so much better that the extra expense is more than justified.

The value of internal medication in psoriasis is just as equivocal, if not more so, as that of topical therapy. There is no question that many psoriatics respond to such treatment. In cases of short duration, we prefer large doses of calcium salts in combination with moderate amounts of vitamin D, although the rationale of this

therapy is unknown. The use of arsenic, given as Fowler's solution, has been a generally accepted treatment of psoriasis for many years. We do not favor this substance because of the possibility of producing serious irreparable toxic reactions, and use it only in exceptional cases. A great number of other agents have been recommended which may be used advantageously, according to the individual needs of each patient, but they cannot be considered any more specific in their action than the treatments mentioned before. ACTH, cortisone, and the unsaturated fatty acids have been found useless by the majority of physicians.

A change in the patient's diet plays an important part. Restriction of various food constituents, such as proteins, fats, or sodium chloride has been recommended. Whether or not such diets correct any single dietetic or metabolic irregularity is debatable. Most probably it is the change in the general metabolic state, which often follows a drastically altered diet, that yields the result. The currently popular dietary regimen is a sharply restricted reducing diet.

X-ray therapy also is a useful adjuvant, provided it is administered cautiously and with proper timing. It would be wrong to use roentgen rays exclusively at any time, particularly at the beginning of treatment. We see no harm, however, in small fractional quantities, not exceeding the erythema dose, on solitary patches which are already responding, though slowly, to topical or internal therapy. We have been unable to find any evidence for the opinion that roentgen rays may cause exacerbations of the eruption. Also the fact that many cases of x-ray damage have been produced in the treatment of psoriatics does not detract from the therapeutic value of this method, but rather indicates that the agent was used indiscriminately and incompetently. The alpha-radiation of thorium-X, incorporated into an ointment or lacquer, may be particularly helpful in the treatment of inveterate or verrucous patches which often prove resistant to other methods.

#### SUMMARY

No single remedy will cure all cases of psoriasis, and our understanding of the therapeutic agents is pitifully limited. It would be wrong to infer, however, that our medicaments are

valueless because we do not understand their action in this disease. The good results obtained in hospitalized patients under expert care indicate that prognosis is not as poor as is often stated. Our therapeutic efforts will be doomed, however, if we fail to combine them with the following fundamental precepts: an understanding of the patient's problems and a willingness to help and

encourage him, and faith in the value of the time tested methods at our command. With your permission, I should like to close with a quotation from our colleagues, Doctors Murrell, Sr. and Jr.: "Maybe the milk of human kindness is synergistic to tar and chrysarobin, in a measure we wot not of."

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## The Presenile Psychoses

Herman Josephy, M.D.  
Chicago

Textbooks on psychiatry traditionally treat several types of psychotic states or rather dementias under the common heading of "presenile psychoses" — this term assuming, that these dementias have some kind of relationship to the senile dementia proper.

The two main representatives of these presenile psychoses are Alzheimer's disease and Pick's disease. Both of them are true morbid entities. The first one takes its name from Alzheimer, the second from Arnold Pick, a neurologist from Prague, not to be mistaken for one of the other Picks who have given their names to diseases — to a skin ailment, to the polyserositis and pericardial pseudocirrhosis of the liver, and, in our field, to the Pick-Nieman disease, a lipoidosis akin to the familial amaurotic idiocy.

Alzheimer's disease is not rare in my material from the Chicago State Hospital, and apparently not too rare elsewhere either. I want to present here one case which to some degree is representative for the whole group, but which also exhibits some interesting special features.

Anna R, a white woman, born 1896, was admitted to Chicago State Hospital in 1945, at the age of 49 years. According to the history she had been failing mentally for several years; she became forgetful and disoriented, and apparently experienced hallucinations. Physical examination did not reveal anything significant. Reflexes were normal. However the patient had "again

and again" definite difficulty to find words for trivial items, although, in general, she had a very good command of the English language and was able to explain even the meaning of rather unusual words. She could count, but was unable to enumerate the odd numbers only. She was, as the examiner states, not depressed, but "bewildered." She was cooperative and showed a "rather childish pleasure" when praised for good cooperation. She talked relevantly, but was disoriented as to place and time. She could not repeat 4 digits.

Contrary to the defect in recent memory she could give a rather relevant and detailed story of her life.

Serology was negative.

The diagnosis of an organic brain disease with dementia was made, and it was suggested that this was a case of Alzheimer's disease.

The patient deteriorated rather rapidly. She had at least one convulsion. She died in 1948, 2½ years after institutionalization, at the age of 51 years.

Autopsy revealed an emaciated body; many bedsores were present. Findings in the chest and abdominal cavity were irrelevant.

The brain weighed 1100 gms. The ventricles were distended and the gyri were atrophic. Microscopical examination showed the picture of a typical case of Alzheimer's disease. Cortex and also the basal ganglia exhibited an enormous accumulation of plaques, and a large percentage of the nerve cells had Alzheimer's fibrillary disease. Thus, histopathological findings upon the

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From the Pathology Dept. of the Chicago State Hospital.

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central nervous system confirmed the diagnosis, which was suggested when the patient was admitted.

The family history of this patient is interesting. Her mother died at the Chicago State Hospital, at the age of 53 years. She was demented, when admitted, and expired 3 days later. She was signed out as general paresis, although no serological tests were performed. It seems very doubtful that this woman actually was syphilitic — none of her 8 children seem to have a congenital infection. Most likely, this was a case of Alzheimer's disease.

Among the eight children of this woman is besides our patient another daughter, who died as a patient at a mental hospital, at the age of 55 years. She had a progressive organic brain syndrome. It can be assumed, that she too was a case of Alzheimer's disease.

Two other siblings of our patient are at the present time institutionalized at Chicago State Hospital.

A brother, born in 1880 was admitted in 1947, at the age of 67. He said, he had a kind of stroke some time ago, but thought he was improving. He seemed to be somewhat disturbed but soon he became better. Since he was several times at home on extended visits. Now, at the age of 73, he is a slightly disoriented, euphoric and garrulous senile, quite well preserved for his age and able to take care of himself and even to run occasional errands.

The other sibling who is in the hospital, is a sister. She was born in 1886. She was admitted in 1947, at the age of 61. She had been forgetful for some time, misplaced things at home, and reacted to her condition in a paranoid manner, accusing people of stealing, and of mistreating her. On admission, she seemed to be alert and attentive, and not childish. Memory defects were evident, although in general she was "well oriented." A Rohrschach test pointed to a paranoid condition. Physical examination was essentially negative.

Now, at the age of 67, and six years after her commitment, the patient is still up and around. She is fairly well preserved for her age. She is quite alert and attentive, but has very marked defects of memory and is disoriented in all spheres. She has definitely a kind of insight and awareness of this defect, and like her sister, she

is bewildered: "I cannot understand what happened to me. I cannot remember anything any more" — Occasionally she has difficulties in finding words. In general, the clinical picture seems very similar to, if not identical with that of her sister — an organic brain syndrome, which does not quite fit into the diagnosis of a senile dementia.

To sum up — we have a patient with proven Alzheimer's disease, whose deceased mother and sister most likely had the same ailment. Two aged siblings, still alive, are patients in a mental hospital. Thus, our case is one of the increasing number of familial Alzheimer cases, which have been reported by now. It has some special features of interest. There is the sister alive, now out of the age of the presenium, who evidently has the family disease. This indicates that Alzheimer's disease may not be confined to the presenium but may develop later in life. Unfortunately up to now we are not able to distinguish such cases from true senile dementia on the basis of the neuropathological findings. Furthermore, there is the institutionalized brother, now 73 years old, with a mild senile dementia. His case might suggest that the relationship between the severe presenile dementia of the Alzheimer type and the senile dementia proper is not too close.

Contrary to Alzheimer's disease, Pick's disease seems to be extremely rare in this part of the U.S. I have found one case only in more than 1000 autopsies which I have performed at the Chicago State Hospital.

This incidence is in contrast to the experience which I have had before. At the mental hospital in Hamburg I have seen about 3000 autopsies performed from 1914 to 1933. I think this figure is a fair estimate, rather too low than too high. In this material we had at least 10 cases of verified Pick's disease. In these approximately 3000 postmortems were quite a percentage performed upon persons in younger age groups than come to my attention at Chicago State Hospital. The impression is that Pick's disease is essentially rarer in U.S.A — at least in Chicago — than it is found in Northern Germany, especially in Hamburg. This impression of the rare incidence of Pick's disease in the United States, or certain parts of the United States is supported by a note in Muncie's textbook, who says — edition of 1939 — "There have been no cases so

diagnosed and verified in the history of the Phipps Clinic" (pg 436). Courville, in a very extensive material lists one case only. On the other hand, it seems that Winkelman in Philadelphia has encountered quite a number of verified cases. A valuable study of Morbus Alzheimer and Morbus Pick has been published in 1952 by Torsten Sjögren and co-workers; it brings out a fact of interest in this connection: the authors have 18 cases of Alzheimer's disease and Pick's disease each, verified by autopsy. The cases were collected in Göteborg and Stockholm, that is in the southwestern part of Sweden and in the northeastern part respectively. All 18 cases of Pick's disease were found in Stockholm, and none in Göteborg and on the other hand 16 cases of Alzheimer's disease were located in Göteborg and 2 only in Stockholm.

My case is that of a white woman, who was born in 1893, was admitted to the hospital in 1947 and died in 1952, at the age of 59. The family history is without interest. It seems that five years prior to admission when the patient was 49 years old, her memory became poor and that in the course of the next years she became more and more "disorganized." Finally she could not do housework any more and started to take money from newstands and small articles, which she never used, from stores.

On admission to Chicago State Hospital — she was 54 years old at this time — she was disoriented in all spheres; she was restless and fidgety. She became acutely disturbed, and had to be sent to the hydro ward. Physical examination did not reveal any neurological signs. Serology was negative. In the course of the next five years the patient became more and more demented. Some paranoid features persisted. There was never any sign of a focal lesion, such as aphasia, apraxia or extrapyramidal involvement. The patient died from a bronchopneumonia, at the age of 59.

The brain had a weight of 1000 gms. Gross examination revealed a very marked atrophy of both temporal lobes and also to some degree of the orbital gyri, an atrophy which contrasted strongly to the well developed gyri of the rest of the hemispheres. A coronal section shows that on both sides the second and third temporal convolutions and also the hippocampus are shrunk and very narrow, while the first tem-

poral gyrus is well preserved, like all other convolutions. The basal ganglia have a normal appearance. The white matter of the affected gyri exhibits some loss of myelin.

Microscopical examination reveals an almost complete loss of nerve cells in the severely affected gyri. There is an abundant proliferation of astroglia; occasionally a Hortega cell filled with iron pigment is found. Gitter cells are missing and there is no indication that the degeneration is due to a vascular disease.

Where the cortex is somewhat better preserved, the lower layers are less affected than the upper ones. Here one sees many of the swollen or ballooned or inflated nerve cells which seem to be characteristic, although not pathognomic for Pick's disease. These cells exhibit an enlarged cytoplasm, stained faintly with Nissl methods, and the nucleus is pushed into a corner. Once in a while such cells contain a hyaline argento-philic body.

Upon microscopical examination the process which leads to the disappearance of nerve cells is not as circumscribed and limited as it would appear from the gross picture. The first temporal gyrus, which grossly is not affected exhibits quite a number of these swollen nerve cells and also some loss of nerve cells. Swollen cells are found also in the corpus striatum and in the hypothalamic region — indicating that the process is by no means strictly "lobar."

None of the sections, neither from the atrophic gyri nor from the well preserved ones, exhibits plaques or Alzheimer fibrils.

In general the microscopic findings confirm the diagnosis of Pick's disease in every respect.

Our two cases — the first one of Alzheimer's disease and the second one of morbus Pick confirm what by now has been stated by many authors, namely that it may be difficult, if not impossible to make a differential diagnosis between both in vivo. Pick's conception was that he was dealing with cases of senile dementia exhibiting signs of focal brain involvement, such as aphasia and apraxia, and that in these cases there was a local accentuation of the senile process in the brain. But not all cases which classify as morbus Pick on the basis of the neurohistological findings, have focal signs clinically. On the other hand, our Alzheimer case proves that there may be focal signs — such as

difficulty in finding words — in Alzheimer's disease. Sjögren has described a large number of neurological signs as characteristic for morbus Alzheimer; however, it seems that not all verified cases fit into his outline either. The final differential diagnosis between both diseases rests on the microscopical examination of the brain.

When Alzheimer's disease was described first, it was assumed that it had a very close relationship to the senile dementia proper, and that it represented a senile process developing prematurely and in an especially severe form; hence the classification as a "presenile" dementia. This conception was based upon the fact that plaques and Alzheimer's fibrillary changes were found in both, senile dementia and Alzheimer's disease. Formerly, these plaques and fibrillary changes were considered to be almost pathognomic for the senile brain. We have learned by now that this is not true. Plaques and Alzheimer fibrils may be found in conditions which definitely are not senile and on the other hand they may be missed in brains of senile demented patients. Thus, the similarity — or, if one wants, identity — of the neuropathology in Alzheimer's disease and senile dementia most likely is "purely incidental."

The idea that Pick's disease has some relationship to senile dementia is based upon the

misconception, that the lobar atrophy found in the brains of these cases is a focal exaggeration of the senile process — which definitely is not true. The neuropathological changes in morbus Pick are entirely different from those found in any case of senile dementia.

Thus, neither Alzheimer's nor Pick's disease has any actual relation to senile dementia. It is very doubtful that they develop always during the presenium. They are two different morbid entities in their own right and should find their place where they belong in the system, in the group of the heredodegenerative diseases of the central nervous system.

It is unnecessary and not justified by the facts, to have a special group of "presenile" psychoses, on the basis only that cases classified here develop during the presenium. Other organic brain diseases frequently start in the presenium too — such as Huntington's chorea and arteriosclerotic dementia — and are not classified as presenile psychoses. To my opinion the term presenile psychoses is obsolete and should be dropped from the list.

#### REFERENCES

- An almost complete list of publications on Alzheimers and Picks disease will be found in:  
Sjogren, Torsten; Hakon Sjogren and Ake G. H. Lindgren: Morbus Alzheimer and Morbus Pick: A Genetic, Clinical and Patho-Anatomical Study. *Acta psychiatrica and neurologica scandinavica*. Supp. 82. 1952.

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## INCREASING NUMBER OF ALIEN INTERNS AND RESIDENTS

Willard C. Rappleye, Dean of the Faculty of Medicine at Columbia University, has commented on the present situation as follows: "The most recently published reports state that one-seventh of the internships and residencies of the approved hospitals of the United States is filled by aliens. Unpublished reports indicate that the ratio may now be close to one in four. For example, approximately 48 per cent of all internships and residencies of the hospitals in New Jersey are

filled by aliens. Although it is no reflection whatsoever on individuals or their earnest efforts to obtain a professional education, a great many from foreign countries are graduates of institutions which do not provide the quality of instruction required of American schools. The situation represents a new phenomenon in American medicine which has a direct bearing on the maintenance of the standards of medical practice throughout the country." *James M. Faulkner, M.D., Editor, B.M.Q., Boston, Massachusetts, Alien Interns. B.M.Q., December, 1953.*

# Unique Fund Raising Plan

**Agnes F. Florence, R.N., Supt., and Howard Edwards, Jr., M.D., President,  
Dixon Public Hospital  
Dixon**

We have a plan for raising funds by the staff for a hospital building fund which has worked very satisfactorily for the past year. It has been accepted by the staff as being very fair. We feel that it is much easier to raise funds this way than to be asked for a donation amounting to several thousand dollars.

When a community has a fund-raising drive for building a hospital or adding to an older hospital, the staff of physicians is expected to donate a heavy share of the fund. Often the public feels that the hospital is the doctor's "workshop", and that because of this they should donate heavily. Whether or not we feel this way or feel that a hospital is a public institution that we all should support on equal terms, doesn't seem to matter. The physicians usually end up having to donate a heavy percentage. This is a real problem for most hospital staffs because the amounts donated never seem fair to the individual physician. Dr. Charles Lesage, Dixon, Illinois, devised a plan which has worked beautifully, and we feel that it might be worthwhile passing on the mechanics of this plan for use in other communities.

The individual staff physician's donation is based on the hospital days of his own patients. The more patient days he has, the more he donates. Each patient-hospital day is called one unit. We arrived at a unit being the

average rate for hospital beds which figured out \$10.00 per day. Each anesthetic is designated one unit for the private anesthesiologists. For the x-ray department, each \$10.00 amount of x-ray is one unit. For the pathology department, it is the same.

Because of the chronically ill patients, a maximum of 30 hospital days can be counted for each patient. Each unit is counted as a \$.50 charge to the physician, and he is sent a monthly statement. All public aid and charity patients are charged to the doctor at the same rate. This tends to move charity and public aid patients sooner than previously. This charge has been in effect for one year now, and the collections have been 100%. The payments by each physician average \$30.70. The statements to individuals may run as high as \$300.00 per month. We have collected over \$8,000.00 in one year. Our goal is \$60,000.00. When we get ready to have a drive for a building fund, we will be able to notify our community that the staff has already donated \$60,000.00, and we feel that the local industries and business people, as well as the public in general, will be more generous in their donations if they feel we have done our share. The fund is kept in a separate bank account and records are maintained listing each individual's donations. If we decide not to build when we reach our goal, the money can be returned.

## CASE REPORTS



### Corrosive Esophagitis Due to Nitric Acid

**Paul H. Holinger, M.D.,  
Marvin J. Tamari, M.D., and  
Stanley H. Bear, M.D.\*  
Chicago**

A case of corrosive esophagitis following the ingestion of nitric acid is presented, showing the extent of damage to the esophagus and stomach.

Acid burns are much less common than alkaline caustic burns and appear to be much more severe, causing early extensive erosion and necrosis of the esophageal and gastric walls, and often complicated by the expulsion of a mold of the entire esophagus.

In the case presented, a 56-year old white male accidentally ingested 30 to 40 cc. of concentrated nitric acid. Early treatment consisted of neutralizing agents and control of shock and pain. Due to the patient's inability to swallow, a Levine tube was carefully introduced on the third day for the dual purpose of feeding and

maintaining a patent esophageal lumen. The patient vomited the Levine tube on the ninth day, and shortly afterward, expelled the intact inner lining of his esophagus. No immediate after effects were noted until the twelfth day when he began vomiting blood, necessitating a tracheotomy and transfusions for shock condition, with death occurring on the 14th day from a massive gastric hemorrhage.

Post-mortem findings revealed five perforations of various sizes in the esophagus with complete loss of mucosal lining and evidence of a broncho-esophageal fistula. The stomach showed an absence of the mucosa over the fundus and the proximal part of the antrum, with numerous shallow ulcerations. A large 10 cm. abscess was found in the area of the cardia, communicating with the stomach through a perforation.

An experimental study on a dog was conducted with the introduction of 5 cc. of concentrated nitric acid into the dog's esophagus, and after 60 hours, the dog was killed and the esophagus and stomach were removed for pathologic study. The study shows the early damage to the esophagus and stomach caused by an acid burn, for the

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**\*Major, MC USAF. The opinions expressed are those of the authors and do not necessarily represent the opinion of any department of the Department of Defense.**

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purpose of determining the proper method of early treatment.

Caution is emphasized in the diagnosis of such cases, because the extent of damage is often unable to be fully determined.

The choice of therapy depends on the degree of damage, which is based on three classifications: the mild, the moderately severe, and the severe. The first consideration of treatment is prophylaxis. In the actual treatment of a severe acid burn, the patient must first be considered as a whole, after which it is imperative that early treatment and dilatation be instituted. The first step is usually the giving of a neutralizing substance, control of shock and pain, and antibiotics and chemotherapy for the prevention of secondary infection and complications. A Levine tube can be carefully introduced in the early case to help maintain nutrition and a patent esophageal lumen.

Some authors advocate early bouginage for the prevention of strictures, while others believe bouginage should not be performed until later, from 10 to 14 days. One of the more conservative means of bouginage is the passing of an olive-tipped bougie over a previously swallowed thread, which is used as a guide. Another method is retrograde dilatation through a previously performed gastrostomy, which is particularly helpful in multiple strictures.

In cases of complete atresia, esophagoscopic bouginage may be performed from above and from below through the gastrostomy opening,

with the aid of a biplane fluoroscope. The preferred method is early dilatation with mercury-filled bougies, except in very severe acid burns. Where the stomach has been severely damaged, jejunostomy rather than gastrostomy is recommended.

All severe esophageal burns should be approached seriously, due to the high number of complications and fatalities resulting from the ingestion of corrosive substances.

## DISCUSSION

Dr. Paul H. Holinger, Chicago: This paper demonstrates the additional severity of acid burns beyond the severe and more frequent alkali burns. The course of this patient is not at all unusual and similar cases have been reported in which the patient coughed out an entire mold of the esophagus, a dramatic occurrence as any one can imagine. We were very much impressed with the rapidity of the downhill course of this patient, a succession of events that does not occur in the same manner in patients who have swallowed caustics.

We have a short strip of film to show the nature of the burn in the pharynx. (movie)

One sees the exudate covering the uvula and the pharyngeal walls, and yet little in the posterior part of the pharynx. The rather minimal degree of the burn in comparison to the manner in which such burns are usually seen, possibly put us off guard and we attempted simply to keep nourishment going by means of a Levine tube. I think the suggestion that has been made of an early jejunostomy rather than gastrostomy in these patients is an extremely important one because of the fact that the stomach and intestines are also so extensively burned in the acid cases.

# PATHOLOGY CONFERENCES

EDWIN F. HIRSCH, DEPARTMENT EDITOR



Symptomless carcinoma of the cardia of the stomach.  
Pneumococcus meningitis secondary to lobar pneumonia.

**Edwin F. Hirsch, M.D.**

St. Luke's Hospital  
Chicago

## **SYMPTOMLESS CARCINOMA OF THE CARDIA OF THE STOMACH**

A white male aged 55 years entered St. Luke's Hospital on September 28, 1953 in the care of Doctor Paul Holinger because of a persistent pain in the left side of the neck of about two months duration. A biopsy of the mass elsewhere was diagnosed as "anaplastic carcinoma." For two weeks he had difficulty in swallowing. His temperature was normal, so also his pulse, respirations, and blood pressure. In the left side of his neck was a fixed, non-tender hard mass 4 by 3 cms. which extended behind the left clavicle. The blood had 4,210,000 red blood cells and 12,400 leukocytes per c.mm. The hemoglobin was 12.4 gms. percent. On the third day an esophagoscopy disclosed a granular constriction of the esophagus 24 cms. from the incisor leveled (upper alveolus) and the biopsy was reported as an ulcerative inflammation. Three days later the second esophagoscopy disclosed no tumor. However the patient complained of pain in the left thigh and

a tumor nodule was found in the lower portion of this extremity. A biopsy taken on October 12 was reported as metastatic carcinoma (Figure 1) and the comment was made that the primary focus was in mucosal tissues of pavement epithelium (squamous cell). Examination of the nasopharynx, the hypopharynx and more esophagoscopies yielded no information. Roentgen examinations revealed an emphysematous chest, but no lesions of the spine and pelvis. He was given nitrogen mustard and sedatives. On November 6, 1953 he developed a right hemiplegia, became comatose and died that night.

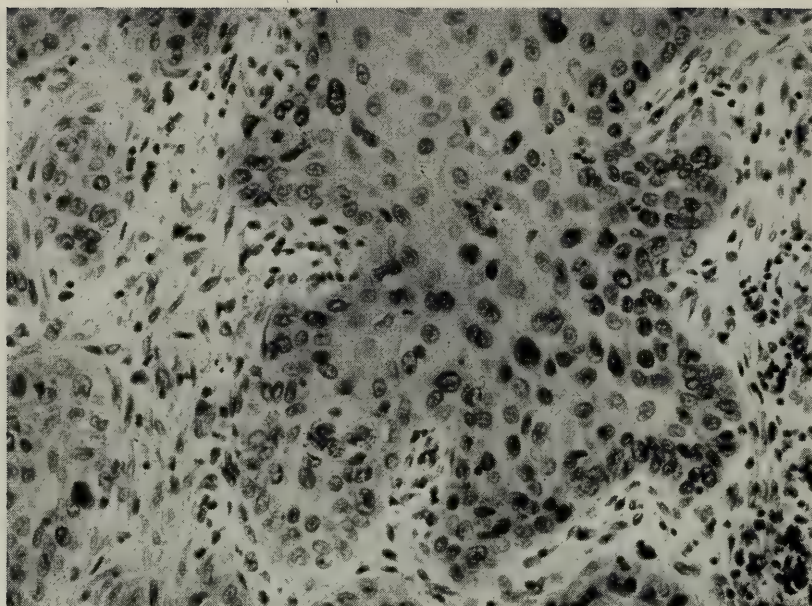
The essentials of the anatomic diagnosis of the necropsy (trunk) are:

Diffusely infiltrative carcinoma of the cardia of the stomach;

Extensive metastatic carcinoma of the skin and tissues of the left side of the neck;

Metastatic carcinoma of the mediastinum and of the left thigh;

Acute verrucous endocarditis of the aortic and mitral valves of the heart;



**Figure 1.** Photomicrograph illustrating the squamous cell structure of the metastatic carcinoma tissues. (Case 1)

Recent focal infarcts of the myocardium, the spleen, and right kidney;

Extramural carcinoma constriction of the upper portion of the esophagus;

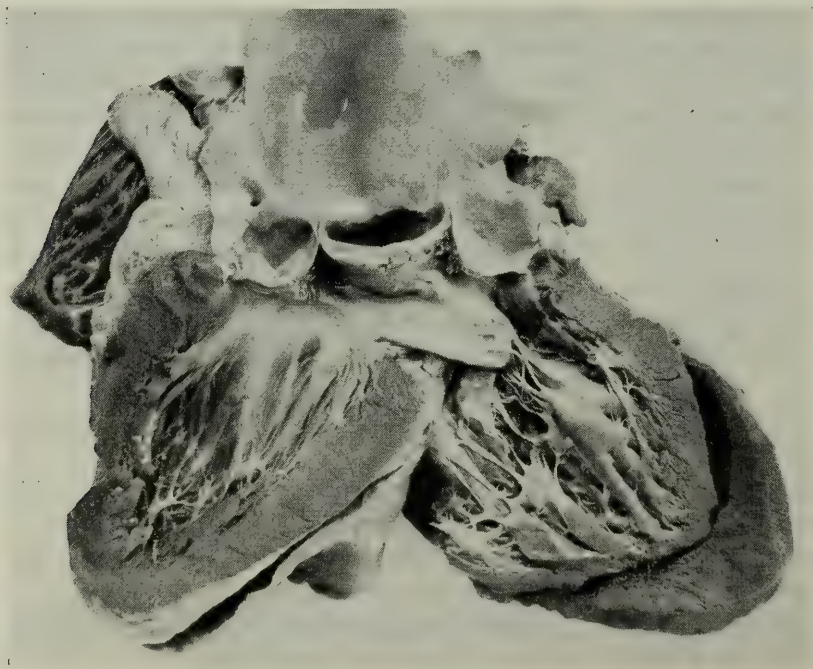
Carcinoma constriction of the inferior vena cava and of the right ureter;

Slight right hydronephrosis;

Etc.

The body weighed 115 pounds. On the left side of the neck anteriorly was a hard adherent mass 12 by 5 cms. and on the medial surface of the left thigh was a surgical biopsy scar 12 cms, long over a poorly defined mass 12 by 5 cms.

Along the lesser curvature of the stomach beginning at the esophagus and extending 8 cms. was a gray thickening that spread into the anterior wall 3 cms. The stomach was opened along the greater curvature and on the lesser curvature beginning 4 cms. beyond the esophageal opening was a firm gray mass 8 by 4 cms. and 1 cm. thick. The upper portion of the esophagus, just above the bifurcation of the trachea was constricted by indurated tissues around the outside, but the lining at all levels was unbroken. The parabronchial lymph nodes were enlarged and black with carbon. The heart weighed 320



**Figure 2.** Photograph illustrating the fused commissure between the right and left cusps and the acute verrucous endocarditis of the aortic leaflets. (Case 1)

gms. The valvular and other structures on the right side had no significant changes. The auricular surface of the free margin of the anterior mitral leaflet had granular gray vegetations that covered about 75 percent of its circumference, the largest 1 cm. in dia. The posterior leaflet had a few. The right and posterior aortic cusps were fused by fibrous tissue to the free edge so that the opening was an irregular slit 2 cms. wide. Granular gray vegetations covered approximately 60 percent of the line of approximation of the aortic leaflets (Figure 2). The myocardium of the left ventricle had focal hemorrhagic gray-yellow tissues ranging to 6 mms. dia. The posterior surface of the upper portion of the right kidney had a recent hemorrhagic infarct 2 cms. in dia. The spleen had another 3 cms. in dia. Histologically the carcinoma tissues in the stomach and elsewhere had anaplastic epithelial cells that ranged in size, many with more than one nucleus, singly or in groups of several and without differentiation into gland structures.

#### COMMENT

Small infiltrative carcinomas near the esophageal opening of the stomach may fail to cause clinical symptoms. As in this patient, the metastases dominated the clinical progress of his illness. Despite the positive evidence of cancerous tissues in the biopsies, esophagoscopies and roentgen examinations did not reveal the primary focus at the esophageal end of the stomach. A necropsy is necessary to unravel such a diagnostic problem.

### **PNEUMOCOCCUS MENINGITIS SECONDARY TO LOBAR PNEUMONIA**

A white woman aged 68 years entered St. Luke's Hospital on October 27, 1953 in the care of Doctor Walter Hoeppner and died the same day. She had been found unconscious in her apartment that day by a neighbor. On the basis of a preliminary examination a tentative diagnosis of cerebrovascular accident was made and she was sent to the hospital. She had been a patient at the Kankakee State Hospital from about 1935 to 1945 and there received insulin shock therapy for paranoia. Apparently she had been in good health for the past ten years.

When examined at St. Luke's Hospital the

lungs were thought to be clear except for a few rales at the base. Her blood pressure was 120/70 mms. Hg., the pulse 120 and the respirations 30 per minute. The temperature was 101.6° rectally and rigidity of the neck was noted. The deep tendon reflexes were present and equal, the Babinski was absent. The spinal fluid had a maximum pressure of 540 mms. water, was turbid, had 850 cells per c.mm. a large percent polynuclear leukocytes, and sugar less than 7 mgms percent. A direct stain of the spinal fluid demonstrated many gram-positive lancet-shaped diplococci which in cultures were identified as pneumococcus. The blood had 22,300 leukocytes per c.mm. of which 49 percent were polynuclear. The urine contained 50 mgms per cent albumin but no sugar. She failed to respond to supportive and antibiotic therapy and died about 10 hours after admission.

The essential portions of the anatomic diagnosis of the necropsy (complete) are:

- Lobar pneumonia of the upper lobe of the left lung — gray hepatization;
- Acute left fibrinous pleuritis;
- Acute catarrhal bronchitis and tracheitis;
- Acute purulent leptomeningitis of the brain;
- Cloudy swelling of the myocardium and parenchymatous tissues;
- Hyperplasia of the spleen;

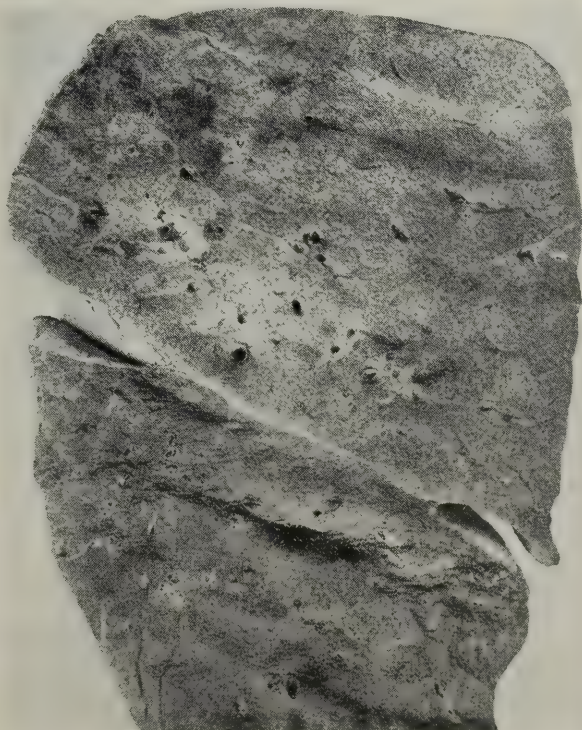
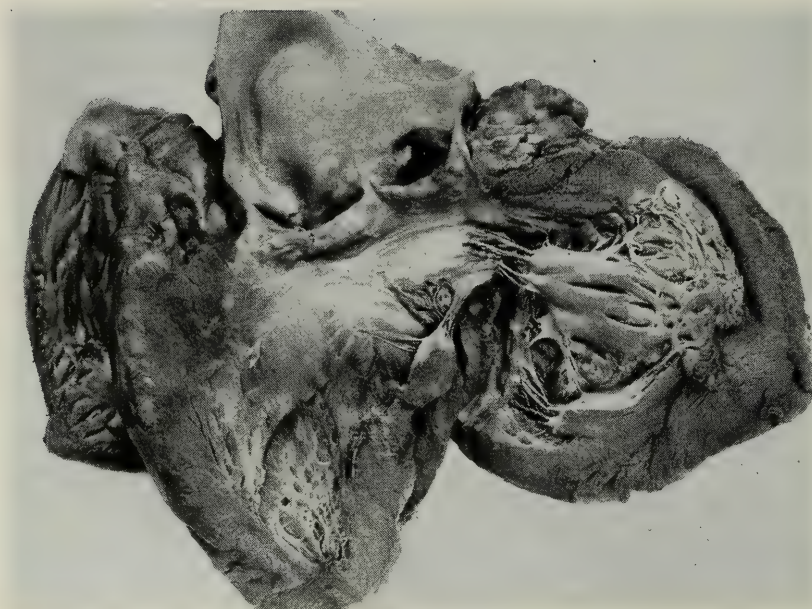


Figure 3. Photograph illustrating the lobar pneumonia of the upper lobe of the left lung. (Case 2)



**Figure 4. Photograph illustrating the chronic fibrous changes of the aortic leaflets. (Case 2)**

Fatty changes of the liver;  
Diminished and irregularly distributed yellow  
lipid of the cortex of the suprarenal glands;  
Etc.

The right lung weighed 670 gms. was moderately expanded and at the apex had fibrous adhesions with the chest. Posteriorly it was edematous and hyperemic. The left lung weighed 1130 gms. and the pleural surfaces, especially of the upper lobe were covered with fibrin. The upper lobe formed about two-thirds of the entire volume of the lung and was consolidated throughout. Surfaces made by cutting the upper lobe were firm gray tissues as with the gray stage of lobar pneumonia (Figure 3). The lower lobe had scattered nodules of gray granular tissues that involved about one-fourth of this lobe, the remaining portions being subcrepitant and edematous. Cultures of the upper lobe tissues of the left lung and of the spinal fluid yielded pneumococcus. The brain weighed about 1370 gms. The spinal fluid was turbid, the leptomeninges especially at the base

had gray-green fibrinous exudates. The frontal, ethmoidal, sphenoidal and maxillary sinuses of the cranium and the middle ears had no exudates. The heart weighed 500 gms. The leaflets and other structures of the heart had no changes except the aortic. The right and posterior leaflets of this valve were fused and the free margin of these had several fibrous thickenings (Figure 4). The fused commissure tissues were calcified. The left cusp had no changes. The kidneys weighed, the right 110 gms., the left 120 gms., the spleen 100 gms., and the liver 1900 grams.

#### COMMENT

Pneumococcus meningitis secondary to lobar pneumonia is a serious complication. The primary lung disease can be overlooked when an upper lobe is involved. This is especially true if the patient at the first examination has symptoms of meningitis. Then, middle ear and cranial sinus infections as the primary focus for the meningitis receive first consideration, and the disease in the lungs is not suspected.

One Hundred Fourteenth  
ANNUAL MEETING  
ILLINOIS STATE MEDICAL SOCIETY



Hotel Sherman, Chicago  
May 18, 19, 20, 21, 1954

# Program Summary

## TUESDAY, MAY 18

### In the Morning:

Section on Eye, Ear, Nose and Throat...  
 ..... New Mezzanine Room  
 Section on Anesthesiology.....  
 ..... Jade Room, #103  
 Section on Obstetrics and Gynecology  
 ..... Old Chicago Room #101  
 Section on Cardiovascular Disease....  
 ..... Gold Room, #114  
 Physicians' Association .....  
 ..... Emerald Room #104  
 HOUSE OF DELEGATES... Louis XVI Room

### At Noon:

### In The Afternoon:

GENERAL ASSEMBLY.... The Ball Room  
 Section on Radiology (3:30 p.m.).....  
 ..... Emerald Room, #104

### In The Evening:

Public Relations Dinner..... Crystal Room  
 Hospitality Hour (9:00 p.m.).....  
 ..... The Bal Tabarin

## WEDNESDAY, MAY 19

### In the Morning:

Women Physicians Breakfast (8:00 a.m.)  
 ..... Room 107  
 Section on Eye, Ear, Nose and Throat..  
 ..... New Mezzanine Room  
 Section on Pediatrics.... Louis XVI Room  
 Section on Surgery..... Crystal Room  
 Section on Dermatology, .....  
 ..... Old Chicago Room #101  
 Association of Blood Banks.....  
 ..... Gold Room #114  
 Reference Committees:  
 Reports of Officers (10:00 a.m.).....  
 ..... Ruby Room, #113  
 Councilor Reports (10:00 a.m.).....  
 ..... Gold Coast Room, #111  
 Standing Committees (10:00 a.m.)..  
 ..... Holiday Room, #105  
 Committee "A" (10:00 a.m.).....  
 ..... Time Room, #110  
 Committee "B" (10:00 a.m.).....  
 ..... Life Room, #108

### At Noon

Pediatric Luncheon..... Louis XVI Room  
 Section on Surgery.... Jade Room, #103

50 Year Club Luncheon.....

### In the Afternoon:

GENERAL ASSEMBLY.... The Ball Room  
 Reference Committees:  
 Committee "C" (2:00 p.m.).....  
 ..... Ruby Room, #113  
 Committee "D" (2:00 p.m.).....  
 ..... Time Room, #110  
 Committee "E" (2:00 p.m.).....  
 ..... Life Room, #108  
 Miscellaneous Business (2:00 p.m.)..  
 ..... Holiday Room, #105

### In the Evening:

Annual Dinner..... The Ball Room

## THURSDAY, May 20

### In the Morning:

Section on Allergy..... Room #107  
 Illinois Chapter, American College of  
 Chest Physicians..... Crystal Room  
 Section on Medicine.....  
 ..... Old Chicago Room, #101  
 Section on Pathology, Emerald Room, #104  
 Section on Preventive Medicine and  
 Public Health..... New Mezzanine Room  
 At Noon:  
 Luncheon: Section on Allergy. Room #107  
 Illinois Chapter, American College of  
 Chest Physicians..... Crystal Room  
 Section on Preventive Medicine and  
 Public Health..... Ruby Room, #113  
 Phi Chi Luncheon.... Holiday Room, #105  
 Section on Pathology..... Emerald Room

### In the Afternoon:

GENERAL ASSEMBLY.... The Ball Room  
 House of Delegates at 3:30 p.m.....  
 ..... Louis XVI Room

### In the Evening:

Loyola Alumni Dinner..... Crystal Room

## FRIDAY, May 21st:

### In the Morning:

Scientific Movies..... Crystal Room  
 HOUSE OF DELEGATES (8:30 a.m.)..  
 ..... Louis XVI Room

## AN EXTRACT FROM THE CONSTITUTION AND BY LAWS

Illinois State Medical Society

CHAPTER XIII, Section 3. All papers read  
 before the Society or any Section thereof,  
 shall become the property of the Society.

Each paper shall be deposited with the sec-  
 retary when read, and presentation of a pa-  
 per to the Illinois State Medical Society shall  
 be considered tantamount to the assurance  
 on the part of the writer that such paper has  
 not already been published.

# Meetings of the House of Delegates

The Outstanding General Practitioner for 1954, GEORGE A. DICUS of Streator, will be honored at the first meeting of the House of Delegates on Tuesday morning, May 18.

The meetings are as follows:

## FIRST MEETING OF THE HOUSE OF DELEGATES

Louis XVI Room

9:00 a.m. Tuesday, May 18.

The first Meeting of the House of Delegates will be called to order by the President, Dr. Willis I. Lewis, for:

Appointment of Reference Committees;

Reports of Officers, Councilors, Committees, etc.

Introduction of resolutions

and for the transaction of any other business which may come before the House.

## COMMITTEE ON CREDENTIALS

The Committee on Credentials will be in the Secretary's Office, The Polo Room, #102, on the First Floor of the Hotel Sherman Monday afternoon, May 17, so that any physicians who are in Chicago before the annual meeting opens, can be certified prior to the time the House opens on Tuesday morning.

The Committee will also meet at 8:00 a.m. on Tuesday morning, May 18, in the entrance to the Louis XVI Room. Delegates desiring to be certified as the official representative

of their county medical societies must present their Credentials to this committee.

## SECOND MEETING OF THE HOUSE OF DELEGATES

Louis XVI Room

3:30 p.m. Thursday, May 20

The Second Meeting of the House of Delegates will be called to order to hear those reports which are ready to be presented.

## THIRD MEETING OF THE HOUSE OF DELEGATES

Louis XVI Room

8:30 a.m. Friday, May 21

The Third (and last) meeting of the House of Delegates will be held Friday morning, May 21, 8:30 a.m. in the Louis XVI Room, to: hear those reports remaining to be presented;

for the Election of Officers, Councilors, Committees, Delegates and Alternates to the American Medical Association

and for the transaction of any other business to come before the House.

At the close of this last meeting ARKELL M. VAUGHN of Chicago will be installed as the new President of the Illinois State Medical Society, and will receive the official gavel from the retiring president, Willis I. Lewis of Herrin.

## The First Day of the Meeting

TUESDAY, MAY 18, 1954

### SECTION ON EYE, EAR, NOSE AND THROAT

Chairman: Earl H. Merz, Chicago

Secretary: Philip R. McGrath, Peoria

Tuesday Morning, May 18

New Mezzanine Room

9:00-9:20 "Management of Exophthalmos in Thyroid Disease"

G. LEROY PORTER and JAMES S. WALKER, Carle Hospital Clinic, Urbana

9:20-9:30 Discussion

9:30-9:50 "Management of Cough in Relation to Operative Procedures"

ALBERT ANDREWS, JR., Assistant Clinical Professor, Bronchoesophagology, University of Illinois College of Medicine, Chicago

9:50-10:00 Discussion

10:00-10:20 "Modern Ophthalmic Therapy by ACTH and Similar Compounds"

DONALD J. BOLES, Instructor, Department of Ophthalmology, Northwestern University Medical School, Chicago

10:20-10:30 Discussion

10:30-11:00 "Some Interesting Oral Lesions" RUSSELL A. SAGE, Assistant Professor of Otolaryngology, Indiana University School of Medicine, Indianapolis, Indiana.

11:00-11:15 Discussion

11:15-11:30 Business meeting and election of Section Officers

11:30-12:00 RECESS TO VIEW EXHIBITS

## SECTION ON OBSTETRICS AND GYNECOLOGY

**Chairman . . . . . James P. FitzGibbons, Chicago**  
**Secretary . . . . . Howard L. Penning, Springfield**

**TUESDAY MORNING, MAY 18**

**Old Chicago Room No. 101**

9:00-9:20—"Management of Varices in Pregnancy"

**ROCCO V. LOBRAICO, JR.**, Instructor, Department of Obstetrics and Gynecology, University of Illinois College of Medicine, Chicago

9:20-9:40—"Cesarean Section in a Small Hospital"

**WILLIAM CURTIS**, Chief of Staff, Memorial Hospital, Springfield

9:40-10:00—"Cytology: Its Practical Application in Gynecologic Diagnosis"

**HAROLD A. GRIMM**, Assistant Professor of Pathology, University of Illinois College of Medicine, Chicago

10:00-10:30—RECESS TO VIEW EXHIBITS

10:30-10:50—"Veratrine Derivatives in the Treatment of Toxemia of Pregnancy"

**PAUL RABER**, Attending Obstetrician and Gynecologist, St. Mary's Hospital, Decatur

10:50-11:10—"The Rh Problem in Obstetrics"

**JOSEPH J. MULLEN**, Instructor, Obstetrics and Gynecology, University of Illinois College of Medicine, Chicago

11:10-11:30—"Abnormal Uterine Bleeding in the Fortyish Woman"

**FRANK M. MAHER**, Instructor, Obstetrics and Gynecology, Northwestern University Medical School, Chicago

11:30—Business meeting and election of Section Officers

## SECTION ON CARDIOVASCULAR DISEASE

**Chairman . . . . . Wright Adams, Chicago**

**Secretary . . . . . V. Thomas Austin, Urbana**

**TUESDAY MORNING, MAY 18**

**Gold Room, No. 114**

9:00-9:20—"Recurrent Myocardial Infarctions"

**CHAUNCEY C. MAHER**, Associate Professor of Medicine, Northwestern University Medical School; Professor of Medicine, Cook County Graduate School, Chicago

9:20-9:40—"Multiple Drug Therapy in the Treatment of Hypertension"

**EDWARD W. CANNADY**, Instructor in Clinical Medicine, Washington University School of Medicine (St. Louis, Missouri), East St. Louis.

9:40-10:00—"Intractable Heart Failure"

**JAMES A. WALSH**, President-Elect, Illinois Heart Association, Peoria

10:00-10:30—RECESS TO VIEW EXHIBITS

10:30-11:00—"Present Status of Heart Surgery"

**THOMAS J. DRY**, Professor of Medicine, University of Minnesota, Mayo Foundation; Head, Section on Cardiology, Mayo Clinic, Rochester, Minnesota

11:00-11:20—"Pathological Changes in Congestive Heart Failure"

**OGLESBY PAUL**, Clinical Associate Professor of Medicine, University of Illinois College of Medicine, Chicago

11:20—Business Meeting and election of Section Officers

11:30—Question and Answer Period  
 Doctors Maher, Cannady, Walsh, Dry and Paul

## SECTION ON ANESTHESIOLOGY

**Chairman . . . . . Max S. Sadove, Chicago**

**Secretary . . . . . Ernest J. Kreutzer, Joliet**

**Alternate . . . . . Arthur T. Shima, Oak Park**

**TUESDAY MORNING, MAY 18**

**Jade Room, No. 103**

9:00-9:20—"Clinical Experience with Oral Analgesics"

**MARY KARP**, Director of Anesthesiology, Wesley Memorial Hospital; Assistant Professor of Surgery, Northwestern University Medical School, Chicago;

**ROSEMARY SUSAT**, Resident, Anesthesiology, Wesley Memorial Hospital, Chicago

9:20-9:40—"The Use of ACTH in Surgical Patients"

**WILLIAM J. GROVE**, Assistant Professor of Surgery, University of Illinois College of Medicine, Chicago

9:40-10:10—RECESS TO VIEW EXHIBITS

10:10-10:30—"Laudolissin — A New Synthetic Muscle Relaxant"

**GORDON M. WYANT**, Assistant Professor of Surgery (Anesthesia); Head of Division of Anesthesia, Stritch School of Medicine of Loyola University; Director of Anesthesia, Mercy Hospital, Chicago

**MAX S. SADOVE**, Professor of Surgery, University of Illinois College of Medicine; Head, Division of Anesthesiology, Research and Educational Hospitals, Chicago

10:30-10:50—"Obstetrical Anesthesia"

**LAWRENCE D. RUTTLE**, Staff Anesthesiologist, St. Joseph and Silver Cross Hospitals, Joliet

10:50-11:20—"The Electro-encephalogram in the Evaluation of the Effects of Anesthetic Agents"

**HENRY E. KRETCHMER**, Associate Professor of Anesthesiology, Western Reserve University; Director of Department

of Anesthesiology, Cleveland City Hospital, Cleveland, Ohio

**GEORGE H. A. CLOWES, JR.**, Senior Instructor in Surgery, Western Reserve University and Associate Visiting Surgeon, Cleveland City Hospital, Cleveland, Ohio

**FIORINDO A. SIMEONE**, Professor of Surgery, Western Reserve University School of Medicine, Cleveland, Ohio

11:20-11:40—"Chlorpromazine in General Anesthesia"

**ARTHUR T. SHIMA**, Division of Anesthesiology, Research and Educational Hospitals, Chicago

**MAX S. SADOVE**, Head, Division of Anesthesiology, Research and Educational Hospitals, Chicago

11:40—Business meeting and election of Section Officers

### PHYSICIANS' ASSOCIATION

of the

#### DEPARTMENT OF PUBLIC WELFARE

Tuesday Morning, May 18, 1954

Emerald Room #104

"Group Psychotherapy in Mental Hospitals"  
..... **Jacob W. Klapman**, Chicago

State Hospital, Chicago

"Sudden Death after Electric Shock Treatment Due to Tracheal and Bronchial Obstruction" ..... **Werner Tuteur**, Elgin

State Hospital, Elgin

"Ocular Manifestations in the Mentally Deficient" ..... **L. B. Kamenetz**, Dixon

State School, Dixon

MANTENO STATE HOSPITAL — "Further Reports of Research Work on Schizophrenic Reactions at Manteno State Hospital"

1. "Pharmacological Aspects" — **E. Pelikan**, M.D., and **C. Pfeiffer**, M.D., Ph.D.

2. "Report of a Typical Study" — **A. Levy**, **M. Raskin**, **M. Sajjadi**, **W. Hamman**, **T. Tausig**, M.D.

3. "Implications for Understanding Schizophrenic Reactions" — **N. Apter**, M.D.

**L. B. Kamenetz**, M.D., President, Dixon

**L. Stolfi**, M.D., Secretary-Treasurer, Lincoln

**Heinz Goldschmidt**, M.D., Chairman Executive Council

**Eric Bock**, M.D., 1st Vice President, Elgin

**Eric Otten**, M.D., 2nd Vice President, Anna

**Martin S. Sloane**, M.D., Chairman Southern District, Anna

**Marianne Chermak**, M.D., Program Chairman, Manteno

### GENERAL ASSEMBLY

TUESDAY AFTERNOON, MAY 18

The Ball Room

Presiding ..... **Earl H. Merz**, Chicago

Assisting .... **George Irwin, Jr.**, Bloomington

1:30-1:40—Opening of the General Assembly  
**WILLIS I. LEWIS**, President, Illinois State Medical Society, Herrin

1:40-2:00—"Diagnosis and Treatment of Common Lesions of the Mouth"

**RUSSELL A. SAGE**, Assistant Professor of Otolaryngology, Indiana University School of Medicine, Indianapolis, Indiana

2:00-2:20—"The Management of Threatened Abortion"

**RICHARD PADDOCK**, Assistant Professor of Clinical Obstetrics and Gynecology, Washington University School of Medicine, St. Louis, Missouri

2:20-2:40—"Problems Associated with the Roentgenologic Diagnosis of Certain Common Pulmonary Lesions"

**C. ALLEN GOOD**, Associate Professor of Radiology, Mayo Foundation Graduate School; Consultant Diagnostic Roentgenology, Mayo Clinic, Rochester, Minnesota

2:40-3:10—RECESS TO VIEW EXHIBITS

Presiding ..... **V. Thomas Austin**, Urbana

Assisting ..... **Max S. Sadove**, Chicago

3:10-3:30—"The Management of Pain"

**DANIEL C. MOORE**, Director of Anesthesia, Virginia Mason Hospital, Seattle, Washington

3:30-3:50—"Present Status of Heart Surgery"

**THOMAS J. DRY**, Professor of Medicine, University of Minnesota, and Mayo Foundation; Head, Section on Cardiology, Mayo Clinic, Rochester, Minnesota.

3:50-4:10—"What Lies Ahead in the Field of Nutrition"

**WILLIAM J. DARBY**, Professor and Head of the Department of Biochemistry and Director of the Division of Nutrition, Vanderbilt University School of Medicine, Nashville, Tennessee.

### SECTION ON RADIOLOGY

Chairman .... **George Irwin, Jr.**, Bloomington

Secretary ..... **E. Kenneth Lewis**, Chicago

TUESDAY AFTERNOON, MAY 18

The Emerald Room, No. 104

3:30 p.m. The guest moderator for the film reading session of the Section on Radiology will be **Dr. C. Allen Good**, Associate Professor of Radiology, Mayo Foundation Graduate School, and Consultant in Diagnostic Roentgenology at the Mayo Clinic in Rochester, Minnesota.

All physicians who are interested will be most welcome at this section meeting.

Following the scientific portion of the program, a business meeting and the election of Section Officers will be held. A Fellowship Hour will close the afternoon activities.

**PUBLIC RELATIONS DINNER  
TUESDAY EVENING, MAY 18  
The Crystal Room**

6:30 p.m. The Public Relations Dinner will be held for the second consecutive year. Any member of the Illinois State Medical Society interested in public relations and the many phases presented in this important field, will be most welcome at the dinner.

Dr. Frank E. Wilson, Director of the Washington, D. C., Office of the American Medical Association, will be the after dinner speaker.

Each county and branch society in Illinois should have some member interested in public relations work attend this dinner meeting and report back to his society in detail relative to the state and national activities in this field.

**THE FELLOWSHIP HOUR  
TUESDAY EVENING, MAY 18  
The Bal Tabarin**

9:00 p.m. The dinners held on Tuesday evening should all adjourn by 9:00 o'clock so that the physicians attending the annual meeting may take part in the Fellowship Hour scheduled for the Bal Tabarin.

All the technical exhibitors will be invited to join with the physicians again this year; the local Technical Exhibit Committee will be given the responsibility of extending the invitation of the Society to the commercial houses to join us again this year in making this an evening of fun and entertainment.

The Society is the host for the evening. Come and get acquainted.

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## *The Second Day of the Meeting*

**WEDNESDAY, MAY 19, 1954**

**Chairman:** ..... Earl H. Merz, Chicago  
**Secretary:** ..... Philip R. McGrath, Peoria

**WEDNESDAY MORNING, MAY 19  
New Mezzanine Room**

9:00-9:20 "A Reference Point System of Interpreting Vestibular Tests"

**A. M. PAISLEY**, Jacksonville

9:20-9:30—Discussion

9:30-11:30 **SYMPOSIUM—"Headache"**

**MODERATOR—WATSON GAILEY**, The Gailey Eye Clinic, Bloomington

9:30-9:50 "Neurological Aspect"

**ERIC OLDBERG**, Head of Department of Neurology and Neuro Surgery, University of Illinois College of Medicine, Chicago

9:50-10:10 "Systemic Aspect"

**THOMAS COOGAN**, Department of Medicine, Northwestern University Medical School, Chicago

10:10-10:30 "Psychiatric I Aspect"

**HUGH CARMICHAEL**, Professor of Psychiatry, University of Illinois College of Medicine, Chicago

10:30-10:50 "Ophthalmological Aspect"

**KENNETH ROPER**, Associate Professor of Ophthalmology, Northwestern University Medical School, Chicago

10:50-11:10 "Otolaryngological Aspect"

**WILLIAM McNICHOLAS**, Dixon

11:10-11:30 Discussion

11:30-12:00 RECESS TO VIEW EXHIBITS.

**WOMEN PHYSICIANS' BREAKFAST  
WEDNESDAY MORNING, MAY 19  
Room 107**

8:00 a.m.

On Wednesday morning, May 19, the women physicians registered at the annual meeting will be the guests of the Illinois State Medical Society at a breakfast meeting.

The speaker will be **THERESE F. BENEDEK**, M.D., certified by the American Board of Psychiatry and Neurology, and a member of the staff of the Institute of Psychoanalysis of Chicago. Her subject will be a review of the recent book, "The Second Sex" written by Simone de Beauvoir.

**SECTION ON PEDIATRICS**

**Chairman:** ..... James B. Gillespie, Urbana  
**Secretary:** ..... Ralph H. Kunstadter, Chicago

**WEDNESDAY MORNING, MAY 19  
Louis XVI Room**

**SYMPOSIUM ON CHRONIC DIARRHEA**

9:00-9:15 "Surgical Implications of Chronic Diarrhea"

**WILLIS J. POTTS**, Associate Professor of Surgery, Northwestern University Medical School; Surgeon in Chief, Children's Memorial Hospital, Chicago

9:15-9:30 "Bacterial Diarrhea"

**JOHN P. BURGESS**, Rock Island

9:30-9:45 "Parasitic Diarrhea"

**JOHN D. STULL**, Olney

9:45-10:00 "Virus Diarrhea"

- W. R. ELGHAMMER**, Danville  
 10:00-10:30 RECESS TO VIEW EXHIBITS  
 10:30-10:45 "Gastrointestinal Allergy"  
**JOSEPH B. SEAGLE**, Carle Hospital Clinic, Urbana  
 10:45-11:00 "Cystic Fibrosis of the Pancreas: Diagnosis and Treatment"  
**BENJAMIN M. KAGAN**, Chairman, Department of Pediatrics, Director of Pediatric Research, Micheal Reese Hospital, Chicago  
 11:00-11:15 "Celiac Disease: Diagnosis and Treatment"  
**JOHN LESTER REICHERT**, Assistant Professor of Pediatrics, Northwestern University Medical School; Children's Memorial Hospital, Chicago  
 11:15-11:30 "Chronic Ulcerative Colitis and Regional Ileitis"  
**JOSEPH B. KIRSNER**, Professor of Medicine, University of Chicago School of Medicine, Chicago  
 11:30 Business meeting and election of Section Officers.  
 11:40-12:00 Questions and Discussion Period

●  
**Illinois Chapter**  
**AMERICAN ACADEMY OF PEDIATRICS**  
**WEDNESDAY NOON, MAY 19, 1954**

**Louis XVI Room**

The Illinois Chapter, American Academy of Pediatrics, will have its annual meeting in conjunction with the annual meeting of the Illinois State Medical Society, on Wednesday noon, May 19, immediately following the scientific meeting of the Section on Pediatrics.

This will be a luncheon meeting, and will be held in the same room as the morning scientific session, thereby facilitating a shift to Academy activities.

The luncheon will be an open meeting. All physicians and their wives are cordially invited to attend. Tickets may be purchased at the meeting; reservations may be made by writing to Dr. John Lester Reichert

1791 Howard Street  
 Chicago, Illinois

●  
**SECTION ON SURGERY**

**Chairman:** . . . . **Arkell M. Vaughn, Chicago**  
**Secretary:** . . . . **Howard P. Sloan, Bloomington**

**WEDNESDAY MORNING, MAY 19**

**The Crystal Room**

9:00-9:15 "Surgical Aspects of Gout"

**JAMES KEANE STACK**, Associate Professor of Bone and Joint Surgery, Northwestern University Medical School; Attending Orthopedic Surgeon, Passavant Memorial Hospital, Chicago

**WILLIAM A. LARMON**, Attending Orthopedic Surgeon, Passavant Memorial Hospital, Chicago

9:15-9:30 "Revascularization of the Ischemic Extremity"

**GEZA deTAKATS**, Clinical Professor of Surgery, University of Illinois College of Medicine; Senior Attending Surgeon, St. Luke's Hospital, Chicago

9:30-9:45 "Certain Aspects of the Treatment of the Acute Traumatic Chest"

**RAY W. FRICKE**, Joliet

9:45-10:00 "Lesion of the Jejunum as the Cause of Obscure Upper Gastro Intestinal Hemorrhage"

**BENTON HOLM** (Former Assistant Professor of Surgery, College of Medicine, University of Vermont), Moline

**LOREN HELFRICH**, Moline

10:00-10:30 RECESS TO VIEW EXHIBITS

**PANEL DISCUSSION ON ABDOMINAL PAIN**

**MODERATOR — ARKELL M. VAUGHN,**  
 Chicago

10:30-10:40 "Significance of Pain in Gall Bladder Disease"

**CHARLES D. BRANCH**, Peoria

10:40-10:50 "Diagnostic Significance of Gastro Intestinal Pain"

**HARRY A. OBERHELMAN**, Professor and Chairman, Department of Surgery, Stritch School of Medicine of Loyola University, Chicago

10:50-11:00 "Nonpenetrating Abdominal Injuries"

**CHESTER C. GUY**, Clinical Associate Professor of Surgery, University of Illinois College of Medicine, Chicago

11:00-11:10 "Gynecological Aspects of Lower Abdominal Pain"

**THOMAS B. WILSON**, Carle Hospital Clinic, Urbana

11:10-11:30 Business meeting and election of Section Officers

Panel Discussion and adjournment

●  
**Luncheon**

**SECTION ON SURGERY**

**WEDNESDAY NOON, MAY 19, 1954**

**Jade Room, #103**

Reservations for this surgical luncheon (at which all physicians interested, will be most welcome) may be made with Dr. Howard P. Sloan, 203 North Main Street, Bloomington, or with Dr. Arkell M. Vaughn, 1180 East 63rd Street, Chicago.

The guest speaker at the luncheon will be Dr. Frederick W. Slobe Chicago, with the Blue Cross — Blue Shield. A general open discussion of mutual problems will be of interest to most physicians.

●  
**SECTION ON DERMATOLOGY**

**Chairman:** . . . . **Francis E. Senear, Chicago**  
**Secretary:** . . . . **Malcolm C. Spencer, Danville**

WEDNESDAY MORNING, MAY 19, 1954

Old Chicago Room, #101

SYMPOSIUM

"MANAGEMENT OF COMMON SKIN DISEASES"

(Papers 15 minutes; Discussion 5 minutes.)

9:30-9:50 "Stasis Dermatitis"

MYRON H. KULWIN, Christie Clinic, Champaign

Discussant: OTTO C. STEGMAIER, Moline

9:50-10:10 "The Management of Lupus Erythematosus with Atabrine and Chloroquin"

RICHARD B. STOUGHTON, Assistant Professor of Medicine, Department of Dermatology, University of Chicago Medical School, Chicago

Discussant: STANLEY E. HUFF, Evanston

10:10-10:30 "Pyodermas"

HILLIARD M. SHAIR, Physicians and Surgeons Clinic, Quincy

Discussant: JEROME M. GREENHOUSE, East St. Louis

10:30-11:00 RECESS TO VIEW EXHIBITS

11:00-12:00 PANEL: "HAND ECZEMAS"

Members of the panel will consist of the Chairman of the Departments of Dermatology from all the medical schools in Chicago, and the out of state guest of the Section on Dermatology.

Kodochromes of exemplary cases will be presented for discussion.

Management will be stressed.

MODERATOR: FRANCIS E. SENEAR, University of Illinois

STEPHEN ROTHMAN, University of Chicago

HERBERT RATTNER, Northwestern University

CLEVELAND J. WHITE, Loyola University

DAVID M. COHEN, Chicago Medical School

CLARENCE S. LIVINGOOD, Physician in charge, Division of Dermatology, Henry Ford Hospital, Detroit Michigan.

12:15-1:15 Luncheon for members of the Section and their guests

Report of the Nominating Committee  
Election of Section officers.

If you care to make reservations for the  
LUNCHEON

of the

SECTION ON DERMATOLOGY

which will be held Wednesday noon, May 19, in the Old Chicago Room, #101, may we suggest that you write to the secretary, DR. MALCOLM C. SPENCER, Adams Building, Danville.

THE ILLINOIS ASSOCIATION OF BLOOD BANKS

WEDNESDAY MORNING, MAY 19, 1954

Room to be announced

9:00 Scientific Program

11:00-12:00 Business Meeting

FIFTY YEAR CLUB LUNCHEON  
WEDNESDAY NOON, MAY 19, 1954  
The Assembly Room

Dr. Andy Hall, Chairman of the Fifty Year Club since its formation in 1937, will preside again this year at the annual complimentary luncheon honoring the members of the Fifty Year Club.

All physicians who have been in the practice of medicine for fifty years or more will be the guests of the Illinois State Medical Society at one of the most popular social functions during the annual meeting of the Society.

All members of the Fifty Year Club are invited to attend.

Tickets for the luncheon are complimentary and may be secured at the ticket desk during the meeting or from Dr. Hall.

GENERAL ASSEMBLY  
WEDNESDAY AFTERNOON, MAY 19  
The Ballroom

Presiding: . . . . . Arkell M. Vaughn, Chicago

Assisting: . . . . . Malcolm Spencer, Danville

1:30-1:50 "Hydrocortone Ointment in Dermatology: Its Effectiveness and Limitations"

CLARENCE S. LIVINGOOD, Physician in Charge, Division of Dermatology, Henry Ford Hospital, Detroit, Michigan

1:50-2:20 ORATION IN SURGERY: "The Cancer-Ulcer Problem of the Stomach"

J. DEWEY BISGARD, Professor of Surgery, University of Nebraska College of Medicine, Omaha, Nebraska

2:20-2:45 PRESIDENT'S ADDRESS: "Not by Works Alone"

WILLIS I. LEWIS, President, Illinois State Medical Society, Herrin.

2:45-3:15 RECESS TO VIEW EXHIBITS

Presiding: . . . . . James B. Gillespie, Urbana

Assisting: . . . . . Ralph H. Kunstadter, Chicago

3:15-3:35 "Surgical Treatment of Coronary Arterial Heart Disease"

CHARLES P. BAILEY, Professor of Thoracic Surgery, Hahnemann Hospital, Philadelphia, Pennsylvania.

3:35-3:55 "Some Comments on X-Ray Diagnosis in Pediatrics"

FREDERIC N. SILVERMAN, Associate Professor of Radiology, Assistant Professor of Pediatrics, University of Cincinnati College of Medicine; Director, Department of Radiology, Attending Pediatrician at Children's Hospital, Cincinnati, Ohio.

3:55-4:15 "Congenital Anomalies of the Tracheobronchial Tree"

PAUL H. HOLINGER, Professor of Bron-

choesophagology, University of Illinois  
College of Medicine, Chicago

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**THE ANNUAL DINNER**  
**WEDNESDAY EVENING, MAY 19, 1954**

7:00 o'clock

**The Ballroom**

**PROGRAM**

Leo P. A. Sweeney, Chicago .... Toastmaster  
Immediate Past President

Invocation ..... Dr. Charles R. Goff, Pastor  
Chicago Temple — First Methodist Church

"Our Life with Rex Morgan, M.D." .....  
Dal Curtis, Author  
Marvin Bradley  
Frank Edgington, Artists  
(Dal Curtis is the pen name under which  
Nicholas P. Dallis, M.D. of Toledo, Ohio,  
writes and helps to develop the comic strip  
"REX MORGAN, M.D.")  
Introduction of Past Presidents and Guests ..  
..... Leo P. A. Sweeney, Toastmaster  
Presentation of President's Certificate to  
WILLIS I. LEWIS by F. Lee Stone, Chicago  
Chairman of the Council  
Dinner Music .....  
..... The Irving Margraff Ensemble

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*The Third Day of the Meeting*

**THURSDAY, MAY 20, 1954**  
**SECTION ON PREVENTIVE MEDICINE AND**  
**PUBLIC HEALTH**

**Chairman:** ..... Leroy L. Fatherree, Joliet  
**Secretary:** ..... R. F. Sondag, Murphysboro

**THURSDAY MORNING, MAY 20**

**The Assembly Room**

9:00 "Prophylactic Effect of Gamma Globulin  
in Acute Anterior Poliomyelitis"

**LEONARD M. SCHUMAN**, Deputy State  
Director in Charge of the Division of Pre-  
ventive Medicine, Illinois Department of  
Public Health, Springfield.

Discussion

9:40 "Advances in Vaccines for Prevention  
of Acute Anterior Poliomyelitis"

**HENRY W. KUMM**, Director of Research,  
National Foundation for Infantile Paraly-  
sis, New York, N.Y.

**HOWARD J. SHAUGHNESSY Ph.D.**, Dep-  
uty State Director in Charge of the Divi-  
sion of Laboratories, Illinois Department  
of Public Health, Chicago

Discussion

11:10 "Evaluating Field Trials of Vaccines for  
Prevention of Acute Anterior Poliomyeli-  
tis"

**ROBERT F. KORN**s, Director Bureau of  
Epidemiology and Communicable Dis-  
ease Control, New York State Depart-  
ment of Public Health, Albany, New York.  
On loan to Vaccine Evaluation Center,  
University of Michigan, School of Public  
Health, Ann Arbor.

Discussion

11:50 Business session and the election of  
Section Officers

**LUNCHEON**

**SECTION ON PREVENTIVE MEDICINE AND**  
**PUBLIC HEALTH**

with the

**ILLINOIS ASSOCIATION OF MEDICAL**

**HEALTH OFFICERS**  
**THURSDAY NOON — MAY 20**  
Ruby Room, #113

●

**SECTION ON PATHOLOGY**

**Chairman:** ..... Coye C. Mason, Chicago

**Secretary:** ..... Franklin J. Moore, Chicago

**THURSDAY MORNING, MAY 20**

**Emerald Room, #104**

9:00-9:15 "The Interpretation of Routine  
Blood Counts"

**KEITH TRUEMNER**, Rockford Memorial  
Hospital, Rockford

Discussion

9:20-9:35 "The Appendix, the Pathologist and  
the Surgeon"

**COYE C. MASON**, Assistant Professor of  
Pathology, University of Illinois College  
of Medicine; Pathologist, Grant Hospital,  
Chicago

Discussion

9:40-9:55 "One Foot at the Bedside"

**JOSEPH D. BOGGS**, Evanston

Discussion

REPORTS ON STUDIES BEING MADE BY  
RESIDENTS IN PATHOLOGY

10:00-10:10 "Cytologic Diagnosis of Lower  
Colon Diseases from Lower Colon Wash-  
ings"

**LEO REILLY**, St. Francis Hospital, Evans-  
ton

Discussion

10:15-10:25 "Infarction of Right Cardiac Ven-  
tricle the Result of Stenosis of Right Coro-  
nary Artery Caused by Foreign Body  
("BB" Shot), in Lumen of Coronary  
Artery"

**FRED D. DALLENBACH**, Department of  
Pathology, University of Illinois College  
of Medicine, Chicago

Discussion

10:30-10:40 "A Study of Cross Circulation and Tissue Reactions at Parabiotic Junctions"  
**RICHARD H. ANDRESEN**, Department of Pathology, Presbyterian Hospital, Chicago  
Discussion

10:45-10:55 "Complete Transposition of Main Branches of Blood Vessels of Heart with Patent Foramen Ovale in a Male Individual Eighteen Years Old."  
**SIMAO PUNG**, Department of Pathology, St. Luke's Hospital, Chicago  
Discussion

11:00-11:30 "Recent Advances in Laboratory Diagnosis of Viral Diseases"  
**ALBERT MILZER**, Director, Microbiology Laboratory, Michael Reese Hospital, Chicago  
Discussion

11:35-11:45 "Transfusion Therapy. Progress and Problems"  
**KURT STERN**, Director, Blood Center, Mt. Sinai Research Foundation and Hospital, Chicago  
Discussion

11:50-12:00 "Observations of a Past President of the Illinois Society of Pathologists Regarding the Conduct of Pathology in Illinois"  
**COYE C. MASON**, Chicago  
12:00—Business meeting and the Election of Section Officers.

#### LUNCHEON AND BUSINESS MEETING

Emerald Room, #104

THURSDAY NOON, MAY 20, 1954

Please make luncheon reservations with Dr. J. J. Kearns, Program Chairman

Illinois Society of Pathologists  
1431 North Claremont Avenue  
Chicago 22, Illinois

#### SECTION ON ALLERGY

Chairman: . . . . . **Morris A. Kaplan**, Chicago

Secretary: . . . . . **Ellis A. Canterbury**, Peoria

THURSDAY MORNING, MAY 20

Gold Room, #114

9:00-9:20 "Allergy and the Pediatrician"

**MORRIS A. KAPLAN**, Assistant Professor of Medicine, Chicago Medical School, Chicago

9:20-9:40 "The Value of Skin Tests in Allergy"

**MAX SAMTER**, Associate Professor of Medicine (Allergy Unit), University of Illinois College of Medicine, Chicago

9:40-10:00 "Useful Drugs in the Treatment of Allergy"

**SAMUEL FEINBERG**, Professor of Medicine, Head of Allergy, Northwestern University Medical School, Chicago

10:00-10:30 "Practical Aspects in the Management of Food Allergy"

**THERON G. RANDOLPH**, St. Francis Hospital, Evanston

10:30-11:00 RECESS TO VIEW EXHIBITS

11:00-11:30 "Drug Eruptions (Mechanisms of Cutaneous Drug Eruptions)"

**A. ROSTENBERG**, Professor of Dermatology (Allergy Unit) University of Illinois College of Medicine, Chicago

11:30-11:50 "The Otolaryngologist Looks at Allergy"

**EUGENE L. DERLACKI**, Instructor in Otolaryngology, Northwestern University Medical School, Chicago

11:50-12:00 Business meeting and election of Section Officers.

#### SECTION ON ALLERGY and the ILLINOIS SOCIETY OF ALLERGY

Luncheon

THURSDAY NOON, MAY 20, 1954

Gold Room, #114

Please make your luncheon reservations with Dr. Morris A. Kaplan, 116 South Michigan Ave., Chicago, Illinois

#### SECTION ON MEDICINE

Chairman: . . . . . **Hugh A. Flack**, Chicago

Secretary: . . . . . **George Mason Parker**, Peoria

THURSDAY MORNING, MAY 20

Old Chicago Room, #101

9:00-9:20 "Problems in Antibiotic Therapy"

**HARRY F. DOWLING**, Professor of Medicine, Head, Department of Medicine, University of Illinois College of Medicine, Chicago

9:20-9:40 "Strokes"

**LEWIS J. POLLOCK**, Professor Emeritus, Department of Nervous and Mental Diseases, Northwestern University Medical School, Chicago

9:40-10:00 "Psychiatric Implications of Allergic Disease"

**IRVING L. TUROW**, Peoria

10:00-10:30 RECESS TO VIEW EXHIBITS

10:30-10:50 "Anticoagulant Therapy"

**OVID O. MEYER**, Professor of Medicine, University of Wisconsin Medical School; University Hospitals, Madison, Wisconsin.

10:50-11:10 "Recent Developments in Liver Disease"

**M. MARVIN POLLARD**, Associate Professor of Internal Medicine, University of Michigan Medical School, Ann Arbor, Michigan

11:10-11:30 "Recognition and Diagnosis of Diabetes Mellitus"

**LUCILLE SPRENGER**, Peoria

11:30-11:45 Business meeting and the election of Section Officers.

#### ILLINOIS CHAPTER

AMERICAN COLLEGE OF CHEST PHYSICIANS

## THURSDAY MORNING, MAY 20

### The Crystal Room

9:00 "Modern Trends in Resectional and Surgical Collapse Therapy of Pulmonary Tuberculosis"

**ROBERT T. FOX**, Assistant Chief of Surgery, Municipal Tuberculosis Sanitarium; Clinical Instructor in Surgery, Northwestern University Medical School; Chicago;  
**WILLIAM M. LEES**, Chief of Surgery, Municipal Tuberculosis Sanitarium; Assistant Professor of Surgery, Stritch School of Medicine, Loyola University, Chicago.

9:40 "Pulmonary Fibrosis"

**GEORGE C. TURNER**, Medical Director, Oak Forest Tuberculosis Sanitarium; Assistant Professor of Medicine, Northwestern University Medical School, Chicago.

10:30 **FIRST ANNUAL LECTURESHIP of the Illinois Chapter, American College of Chest Physicians**

"Cancer of the Lung. Difficulties in Diagnosis"

**ALTON OCHSNER**, Director, Ochsner Clinic, Professor and Head of the Department of Surgery, Tulane University School of Medicine, New Orleans, Louisiana.

12:00 **Noon ANNUAL LUNCHEON MEETING, Illinois Chapter — American College of Chest Physicians.**

The Crystal Room — First Floor

President: ..... **Abel Froman**, Chicago

Vice President: ..... **Clifton Hall**, Springfield

Secretary-Treasurer .. **Albert H. Andrews, Jr.**, Chicago

### GENERAL ASSEMBLY

## THURSDAY AFTERNOON, MAY 20

### The Ballroom

Presiding: .... **George Mason Parker**, Peoria

Assisting: ..... **Coye C. Mason**, Chicago

1:30-1:50 "Transfusion Therapy. Progress and Problems"

**KURT STERN**, Director, Blood Center, Mt. Sinai Medical Research Foundation, Chicago

1:50-2:20 **ORATION IN MEDICINE: "Hem-**

**orrhage from the Upper Gastrointestinal Tract"**

**H. MARVIN POLLARD**, Associate Professor of Medicine, University of Michigan; University Hospital, Ann Arbor, Michigan

2:20-2:40 "Epidemic Intelligence"

**LEONARD W. SCHUMAN**, Deputy Director, Division of Preventive Medicine, Illinois Department of Public Health, Springfield.

2:40-3:10 **RECESS TO VIEW EXHIBITS**

Presiding: ..... **Morris A. Kaplan**, Chicago

Assisting: ..... **Ellis A. Canterbury**, Peoria

3:10-3:30 "Treatment of the Lymphoblastomas"

**OVID O. MEYER**, Professor of Medicine, University of Wisconsin; University Hospitals, Madison, Wisconsin.

3:30-3:50 "Allergy and the General Practitioner"

**ETHAN ALLEN BROWN**, Professor of Pediatrics, Tufts College Medical School; Physician in Chief, Allergy Clinic, Boston Dispensary Unit of New England Medical Center; Editor—Annals of Allergy; Folia Clinica Internacional; International Archives of Allergy and Applied Immunology; Boston Massachusetts.

3:50-4:10 "Integration of a Neuropsychiatrist in the Medical Team of the General Hospital"

**BENJAMIN BOSHES**, Professor and Head of Department of Nervous and Mental Diseases, Northwestern University Medical School, Chicago.

### LOYOLA ALUMNI DINNER

Thursday Evening, May 20, 1954

### The Crystal Room

The annual medical alumni dinner of Loyola University will be held on Thursday evening, May 20, in the Crystal Room of the Hotel Sherman.

The class of 1929 — which celebrates the twenty-fifth anniversary of its graduation this year — will be honored at the dinner. Special reunions are also being arranged for several other anniversary classes: 1924 (30th anniversary); 1934 (20th anniversary); and 1944 (10th anniversary).

# *The Fourth Day of the Meeting*

SCIENTIFIC MOVIES  
FRIDAY MORNING, MAY 21, 1954  
Crystal Room  
COYE C. MASON, Director and Chairman,  
Scientific Exhibit Committee

## *Scientific Exhibits*

### COMMITTEE:

Coye C. Mason, Director and Chairman.... Chicago  
..... Chicago  
Hugh A. Flack ..... Chicago  
Arnell M. Vaughn ..... Chicago  
Dwight E. Clark ..... Chicago  
Leo M. Zimmerman ..... Chicago  
J. C. Thomas Rogers ..... Urbana  
Everett P. Coleman ..... Canton  
L. W. Peterson ..... Chicago

Title: "Pharmacologic and Clinical Aspect of  
a New Antibiotic—Tetracycline  
Exhibitor: Robert A. Peterman, Thomas A.  
Garrett, Marvin Ziporyn, Joseph Rich  
Institution: J. B. Roerig Company, Chicago,  
Illinois

Title: Chlorpromazine in the Treatment of  
Nausea and Vomiting of Pregnancy and  
Delivery  
Exhibitor: Mary Karp, Edward N. Dorr, Harry  
B. W. Benaron, Beatrice Tucker, Verner  
E. Lamb, J. William Roddick, Larry Gos-  
sack.  
Institution: Wesley Memorial Hospital, North-  
western University Medical School, Chi-  
cago, Illinois

Title: United Cerebral Palsy of Illinois  
Exhibitor: A. J. Reilly, A. W. Fleming  
Institution: Cerebral Palsy Foundation, Chi-  
cago, Illinois

Title: Prevention of Rheumatic Fever  
Exhibitor: A. R. Eveloff, A. A. Manson  
Institution: Springfield Rural Urban Clinic,  
Springfield, Illinois

Title: Ovarian Carcinoma  
Exhibitor: Frederick H. Falls, Charlotte S.  
Holt  
Institution: University of Illinois College of  
Medicine, and Illinois Department of Pub-  
lic Health, Chicago, Illinois

Title: Recording of the Arterial Blood Pres-  
sure and Arterial Circulation

Exhibitor: Carl A. Johnson  
Institution: St. Luke's Hospital and University  
of Illinois College of Medicine, Chicago,  
Illinois

Title:  
Exhibitor: Maurice H. Cottle, George S.  
Fischer, Roland M. Loring  
Institution: Chicago Medical School, Cook  
County Hospital, Chicago, Illinois

Title: A simple Operation for the Treatment  
of Chronic Heart Disease  
Exhibitor: M. S. Mazel  
Institution: Edgewater Hospital, Chicago, Illi-  
nois.

Title: Better Medical Writing  
Exhibitor: Harold Swanberg  
Institution: American Medical Writers' As-  
sociation, Quincy, Illinois

Title: Medical Education  
Exhibitor: Edward Turner, Edward Leveroos,  
Carl Hienz  
Institution: American Medical Association

Title: Dissection in Continuity for Cancer of  
the Head and Neck.  
Exhibitor: Hans vanLeden, Jesse Waller, Chi-  
cago, Illinois  
Institution:

Title: Hypnosis in Obstetrics  
Exhibitor: William Kroger  
Institution: Chicago Medical School, Chi-  
cago, Illinois

Title: Cutaneous Manifestations of the Leu-  
kemia-Lymphoma Group  
Exhibitor: Samuel Bluefarb, Stephen O.  
Schwartz  
Institution: Cook County Hospital, Northwest-  
ern University Medical School, Chicago  
Medical School, Chicago, Illinois

**Title:** The Lundholm Surgical Lag Screw  
**Exhibitor:** Joseph S. Lundholm, Rockford, Illinois  
**Institution:**

**Title:** The Macon County Blueprint for Public Relations

**Exhibitor:** C. Elliott Bell, Decatur  
**Institution:** Macon County Medical Society

**Title:** Extra Laryngeal Anatomy of the Recurrent Laryngeal Nerve.

**Exhibitor:** Samuel J. Burrows  
**Institution:** Burrows Hospital, Chicago, Illinois

**Title:** Clinical and Histological Findings in 308 Cases of the Diseases of the Nails with New Methods of Treatment

**Exhibitor:** Cleveland J. White and Thomas C. Laipply

**Institution:** Northwestern University Medical School and Stritch School of Medicine of Loyola University, Chicago, Illinois

**Title:** Neuropathic Arthropathy of Feet.

**Exhibitor:** Donald S. Miller, William F. Lichtman

**Institution:** Chicago Medical School, Chicago, Illinois

**Title:** Prevention and Social Aspects of Seasonal Inhalant Allergy.

**Exhibitor:** Oren C. Durham, George Berryman, Ralph F. Voigt.

**Institution:** Abbott Laboratories, University of Illinois College of Medicine, University of Illinois College of Pharmacy, Chicago, Illinois

**Title:** The Graphic Methods in the Study of the Cardiac Patient.

**Exhibitor:** Aldo A. Luisada

**Institution:** The Chicago Medical School, Chicago, Illinois

**Title:** Cancer Research

**Exhibitor:** John A. Rogers

**Institution:** Illinois Division, American Cancer Society, Chicago, Illinois

**Title:** Adequate Low Caloric Diet with Adaptations.

**Exhibitor:** Clara Zempel

**Institution:** The American Dietetic Association

**Title:** Mental Retardation in Children.

**Exhibitor:** Abraham Levinson

**Institution:** Julian Levinson Research Foundation, Cook County Children's Hospital, Chicago, Illinois.

**Title:** Present Status of the Treatment of Varicose Veins Based on Results of 6,000 Ligations.

**Exhibitor:** Anthony Barone, Chicago, Illinois  
**Institution:**

**Title:** Plasma Without Jaundice — An Indispensable Therapeutic Agent.

**Exhibitor:** V. Garrott Allen, Daniel N. Everson, Carolyn Sykes, Morris Levine, Louis Head

**Institution:** University of Chicago, Chicago, Illinois

## *Technical Exhibits*

### **ABBOTT LABORATORIES—Booth No. 103**

#### **A. S. ALOE COMPANY—Booth No. 34**

Visit Booth No. 34 where the Aloe representative will show you a cross section of the complete line of physicians' equipment and supplies carried by the A. S. Aloe Company. Highlighted will be New Model Steeline — tomorrow's treatment room furniture today — featuring the body contour table top, magnetic door catches, and advanced design all in new decorators' colors.

### **AMERICAN HOSPITAL SUPPLY CORPORATION—Booth No. 48 & 104**

American Hospital Supply Corporation will have on display the complete line of Baxter

intravenous solutions and accessory sets, including the new electrolyte solutions, as well as Gentran, an effective, proven plasma volume expander for use in the treatment of shock, and the new Plexitron Blood Pump for safe, rapid pressure transfusions with expendable equipment.

We will also exhibit the Coreco Automatic Camera for taking a technically and clinically accurate photograph of any body surface from a minute lesion to large body areas, or any body cavity.

#### **AMERICAN LIMB, INC.—Booth No. 13**

American Limb, Inc., 1728 West Ogden Avenue, Chicago 12, Illinois, is the first prosthesis manufacturer to conduct a medically

supervised amputee walking school.

American is the exclusive Illinois distributor of the amazing new German Otto Bock "Controlled" knee. The amputee is relieved of constant strain when walking down steps, inclines or rough ground inasmuch as this knee cannot buckle or bend — even when weight is applied in a flexed position up to 15 degrees.

**ASSOCIATED CREDIT BUREAUS OF ILLINOIS—Booth No. 45**

An association of Credit Bureaus and bonded Collection offices, representing all the merchants, finance firms, and professional people of the State of Illinois. The Credit Bureau of each community is a clearing house of information on the paying habits of its people, and credit grantors now recognize the importance of prompt payment of medical bills as valuable credit experience.

Medical service accounts must be collected with diplomacy and tact; yet their percentage of recovery must compare favorably with other types of credit. In our booth we will show the facilities and functions of our member offices and how they serve the medical profession.

**AYERST, McKENNA & HARRISON LIMITED  
—Booth 100**

**BABY DEVELOPMENT CLINIC—Booth No. 35**

**THE BAKER LABORATORIES, INC.—Booth  
No. 102**

**BEECH-NUT PACKING COMPANY—Booth  
No. 99**

The new innovation, the 4 oz. box of Beech-Nut Cereal will be featured at the exhibit. The other new products Junior Banana Desert and Strained Plums will also be displayed. Nutritionists will be in attendance to answer any questions regarding these products as well as discussing the regular Beech-Nut Strained and Junior Foods.

**BLUE CROSS PLAN FOR HOSPITAL CARE  
AND BLUE SHIELD MEDICAL-SURGICAL  
PLAN—Booths No. 49 & 50**

**GEORGE A. BREON & COMPANY**

**Booth No. 38**

George A. Breon & Co., distributors of Lanteen product, invites convention members

to their exhibit of reproductions of well-known paintings by famous European artists at Booth 38. Lithographic prints of these beautiful paintings are available upon request. Representatives will also be happy to discuss Lanteen products with visiting members.

**BROWN & WILLIAMSON TOBACCO  
CORPORATION**

**Booths 36 & 105**

**VICEROY (filter top) Cigarettes  
(No. 36 — Viceroy)**

The new King-Size VICEROY filter Tip Cigarette gives the smoker DOUBLE THE FILTERING ACTION to double his smoking pleasure.

There are 20,000 tiny filter traps in VICEROY'S new filter of pure, non-miner ESTRON. It filters the smoke, yet draws freely and gives the smoker the full, rich taste of choice tobaccos.

An explanation of the unique advantages of VICEROY will greatly interest members and guests who visit the VICEROY exhibit.

**KOOL (Mildly mentholated) Cigarettes  
(No. 105)**

Many members of the medical profession are showing unusual interest in KOOL (mildly mentholated) Cigarettes for which there is a wide and growing acceptance among smokers troubled with throat irritations or respiratory disorders.

Members who visit the KOOL exhibit will receive an attractive souvenir and a folder of interesting facts relating to the application of cooling menthol to tobacco.

**CAMERON SURGICAL SPECIALTY  
COMPANY**

**Booth No. 24**

See the Cameron Holder-Handle Type Cauteradio and other Electro-Surgical Units including suction coagulation handle and numerous other accessories for all phases of electro-surgery, cauterization, coagulation, fulguration, desiccation, dehydration and orificial ultra-violet radiation; Electro-Diagnostic lamp and Instrument Outfits; the improved Omniangle Gastroscope; the Boros Flexible Esophagoscope; Coagulair and Dualite Sigmoidoscopes; Tele-Vaginalite; Mirrolite and other Headlites; Binocular Loupe; and new ideas in illuminated specula, endoscopes, retractors and other instruments for general and special diagnosis, treatment and surgery.

**CHICAGO PHARMACAL COMPANY**

**Booth No. 63**

The following Chimedic products are featured: URISED, Nationally-known and clinically proven urinary antiseptic and sedative

tablet; TOLYPHY, the improved spasmolytic tablet combining mephenesin, physostigmine and atropine for a wider range than ever before in muscular relaxation; KATRASUL, a four sulfa combination in both tablet and liquid form; VITANATE pre- and post-natal therapy tablets which contain all the necessary vitamins and minerals plus B-12 and the essential intrinsic factor.

●  
**CHICAGO REFERENCE BOOKS CO.**  
Booth No. 8

●  
**CIBA PHARMACEUTICAL PRODUCTS, INC.**  
Booth No. 107

The Ciba exhibit will feature SERPASIL, a pure crystalline alkaloid of Rauwolfia possessing the essential antihypertensive actions of the whole root. SERPASIL offers mild, gradual sustained lowering of blood pressure with a slowing of the heart rate; a tranquilizing effect beneficial in most cases of hypertension; and unvarying potency.

●  
**THE COCA-COLA COMPANY**  
Booth No. 14

Ice Cold Coca-Cola served through the courtesy and cooperation of the Coca-Cola Bottling Co., of Chicago, Inc., and The Coca-Cola Company.

●  
**COLES ELECTRONIC CORPORATION**  
Booth No. 58

●  
**DANIELS SURGICAL & MEDICAL SUPPLIES**  
Booths 15-16-17

DANIELS on the entire North End of the Exhibition hall will feature this year "A MODEL DOCTOR'S OFFICE" Featuring the Newest and Most Modern Type of Medical Furniture and equipment. Such Lines as HAMILTON Medical Furniture, RITTER'S "Time Saving" and "Energy Saving," electrically operated Examining Table. BURDICK'S EKG, MF- 49 Diathermy, Infra Red and Ultra Violet Lamps and its D-54 Portable Diathermy — The Sensational New EXAMINING LAMP "LUXO," "The Lamp of the Century." AMERICAN & CASTLE Autoclaves, and Sterilizers, ROYAL METAL Reception Room Furniture, PROFEX X-RAY, MC KESSON METABOLOR, JASPER Consultation Room Furniture. The Newest in Proctoscopes, Oscopes, Headlamps and Diagnostic equipment, its line of SKLAR Instruments and top quality Physicians Medical Bags.

●  
**DOHO CHEMICAL CORPORATION**  
Booth No. 4

Auralgan, the ear medication for the relief

of pain in Otitis Media and removal of Cerumen;

New Otosmosan, The effective, non-toxic ear medication which is Fungicidal and Bactericidal (gram negative-gram positive) in the suppurative and aural dermatomycotic ears;

Rhinalgan, the nasal decongestant which is free from systemic or circulatory effect and equally safe to use on infants as well as the aged. Mallon Chemical Corporation, Subsidiary of the Doho Chemical Corporation, is also featuring:

Rectalgan, the liquid topical anesthesia, also for relief of pain and discomfort in hemorrhoids, pruritus and perineal suturing.

●  
**EISELE & COMPANY**  
Booth No. 39

Eisele & Company will display their regular line of clinical thermometers, hypodermic syringes, hypodermic needles, Eco bandages, and specialty glasswear.

●  
**ELI LILLY AND COMPANY**  
Booth No. 2

You are cordially invited to visit the Lilly exhibit located in space No. 2. The display will contain information on recent therapeutic developments and will feature the story of the Lilly Junior Taste Panel. Lilly sales people will be in attendance. They welcome your questions about 'Ilotycin' (Erythromycin, Lilly) and other Lilly products.

●  
**ENCYCLOPEDIA AMERICANA**  
Booth No. 55

For inspection of members and guests of Illinois State Medical Society, we proudly present the greatest of all Americanas, the 1954 edition of the Encyclopedia Americana, world-wide in scope, American in spirit, preferred by educators. Ask any librarian. We will also display the Heritage edition of the Book of Knowledge for children. Both are adapted to the principles of our American school system and both are included in one combination exhibit offer.

●  
**ENCYCLOPAEDIA BRITANNICA, INC.**  
Booth No. 26

●  
**H. G. FISCHER & CO.**  
Booth No. 43

See the new 75 milliamper "Spacesaver" in the H. G. Fischer & Co. booth. It is without parallel in the x-ray industry, with a double-focus tube and transformers enclosed in a

self-contained, shock-proof tube head. It has enough power to meet every radiographic requirement of general practice — the ideal machine for the doctor's own office. Other modern x-ray and F. C. C. approved electro-medical and rehabilitation equipment will also be on display.

●  
**FREEMAN MANUFACTURING COMPANY**  
Booth No. 51

●  
**GENERAL ELECTRIC COMPANY, X-RAY DEPT.**  
Booths No. 20 & 21

●  
**GENERAL FOODS CORPORATION**  
Booth No. 1

●  
**H. J. HEINZ COMPANY**  
Booth No. 60

Don't fail to visit the Heinz booth to receive the very latest information about the Heinz Baby Food line.

Literature available for office use:

Nutritional Data  
Heinz Baby Foods — Variety and  
Ingredient listing check lists

For your patients:

Your Baby's Diet Booklets  
Junior Foods for Older Babies  
Recipe Magic Using Heinz Strained  
and Junior Foods  
Facts About Foods  
Spill-proof Tumblers — premium  
offer

●  
**KREMERS — URBAN CO.**  
Booth No. 64

●  
**LEDERLE LABORATORIES DIVISION**  
American Cyanamid Company  
Booth No. 18

You are cordially invited to visit our exhibit in Booth 18 where you will find our representatives prepared to give you the latest information on LEDERLE products.

●  
**THE LIEBEL-FLARSHEIM CO.**  
Booth No. 22

●  
**LINCOLN LABORATORIES, INC.**  
Booth No. 23

Pioneer Manufacturer of Aqueous Hormone Suspensions Offers Many New Medications!

Lincoln Laboratories will exhibit on new advances in therapy, including Hexathricin Aeropak aerosol spray treatment for burns and skin disorders; COBEDOCE, for broad spectrum oral anti-anemic therapy; ETHAVERINE Hydrochloride, for treatment of cardiovascular diseases; METHIOPLEX for lipotropic therapy; MULTIVITALIN Lyophilized for geriatric and pre and post-operative care; BABE-E-VITA, lyophilized and stable pediatric vitamin supplementation, and ANDESTERONE, pioneer heterosteroid therapy for the menopause and for aeriatic care.

●  
**J. B. LIPPINCOTT COMPANY**  
Booth No. 62

J. B. Lippincott Company presents, for your approval, a display of professional books and journals geared to the latest and most important trends in current medicine and surgery. These publications, written and edited by men active in clinical fields and teaching, are a continuation of more than 100 years of traditionally significant publishing.

●  
**P. LORILLARD COMPANY**  
Booth No. 44

P. Lorillard Company, manufacturers of OLD GOLD and EMBASSY Cigarettes as well as BRIGGS Pipe Mixture and other famous tobacco products will exhibit and demonstrate their new KENT Cigarettes with the exclusive Micronite Filter, which takes out up to 7 times more nicotine and tars than other filter cigarettes.

●  
**MASSACHUSETTS INDEMNITY INSURANCE COMPANY**  
Booth No. 37

●  
**MEAD JOHNSON & COMPANY**  
Booth No. 95

Mead Johnson & Company Booth No. 95 will feature Lactum, Mead's Liquid formula for infant feeding; Poly-Vi-Sol and Tri-Vi-Sol, superior vitamin supplements for infants; Panalins and Panalins-T, new vitamin capsules based on the new National Research Council's recommendations for vitamin maintenance and therapy. Natalins, the smaller, complete prenatal capsules and Mulcin, the new orange flavored vitamin liquid, will also be shown.

●  
**MEDCO PRODUCTS COMPANY**  
Booth No. 28

The MEDCOLATOR Stimulator, for the stimulation of innervated muscle or muscle groups ancillary to treatment by massage, is a low volt generator that will generate plenty of your interest. Electrical muscle stimulation is a valuable form of rehabilitation thera-

py. Be sure to visit our booth for a personal demonstration.

●  
**MEDICAL AIDS, INC.**

**Booth No. 101**

●  
**MEDICAL ARTS SUPPLY CO.**

**Booth No. 7**

Medical Arts Supply Co. and the Medical Arts X-Ray Co. are prepared to serve you with the newest, most modern equipment. Our motto "From a Bank Pin to an X-Ray" completely covers practically every item in the medical field, to accommodate the needs of the physician, clinic or hospital.

●  
**THE MEDICAL PROTECTIVE COMPANY**

**Booth No. 59**

Having completed another year in which not a single policyholder suffered involuntary loss from his own pocket in a malpractice claim or suit defended by this unique organization, despite large losses reported elsewhere, The Medical Protective Company, Specialists in Professional Protection Exclusively since 1899, invite your visit with its representatives at Booth 59. Answers to problems in the Doctor-Patient relationship are yours for the asking.

●  
**MILLER SURGICAL CO.**

**Booth No. 97**

See the Miller Electro-scalpel Model 10V-0 for cutting, desiccating, fulgurating, coagulating etc. a complete portable office unit. Accessories such as Insulated Sanres, Smoke Ejectors also available. In addition we have a complete line of Diagnostic Equipment with illumination and magnification consisting of Otoscopes, Ophthalmoscopes, Eyespuds with Magnet, Transillumination Lamps, Headlights, Vaginal Speculum, Gorsch Stainless Steel Proctoscopes and Operating scopes, Suction Tubes and Grasping Forceps.

●  
**M & R LABORATORIES**

**Booth No. 94**

M & R Laboratories, Columbus, Ohio, Booth 94 "Your SIMILAC representatives are happy to take part in this meeting. They are pleased to have the opportunity to discuss with you the role of SIMILAC in infant feeding. They have for you the latest Pediatric Research Conference Reports. Also available are current reprints of pediatric nutritional interest."

●  
**V. MUELLER & Co.**

**Booth No. 106**

The newest and finest surgical instruments from our own shops and from abroad will

be shown, as well as selected office equipment and newer surgical sundries.

●  
**PARKE, DAVIS & COMPANY**

**Booth No. 32**

Medical service members of our staff will be in attendance at our exhibit for consultation and discussion of various products of particular interest to members of the Association. Important specialties, such as Milontin, Amphedase, Penicillin S-R, Benadryl, Ambodryl, Dilantin Suspension, Vitamins, Oxycel, Thrombin Topical, etc., will be featured. You are cordially invited to visit our exhibit.

●  
**PFIZER LABORATORIES**

**Booth No. 25**

You are cordially invited to visit the Pfizer booth where you will find well-informed representatives who will be happy to supply you with information and answer any questions relative to Pfizer products. Terramycin dosage forms, Bonamine, Cotril, and other Pfizer-Syntex Hormone products will be the feature attraction of the Pfizer exhibit.

●  
**R. J. REYNOLDS TOBACCO COMPANY**

**Booth No. 56**

Welcome to the CAMEL-CAVALIER Exhibit! You are cordially invited to receive a cigarette case (monogrammed with your initials) containing your choice of CAMELS, America's most popular cigarette, or CAVALIERS, the king size cigarette of extra mildness and distinctive flavor.

●  
**A. H. ROBINS COMPANY, INC.**

**Booth No. 108**

ENTOZYME, comprehensive digestant; ROBALATE, antacid-demulcent; and DONNALATE, combining Robalate with the Donnatal formula; are featured at the A. H. Robins exhibit. Also shown are PABALATE, PABALATE-SODIUM FREE and ALLBEE with C. Robins' representatives welcome the opportunity to discuss with physicians the therapeutic advantages of these and other Robins prescription specialties.

●  
**J. B. ROERIG AND COMPANY**

**Booth No. 54**

Members of the Illinois State Medical Society are cordially invited to visit the booth of J. B. Roerig and Company. Professional Service Representatives will be on hand to welcome all interested visitors.

## **SANBORN COMPANY**

**Booth No. 27**

Sanborn instruments to be shown at Booth No. 27 will include the direct-writing Viso-Cardiette; the Metabulator, latest model metabolism tester; and the Electrophrenic Respirator.

Full data will also be available concerning the Sanborn Poly-Viso and Twin-Viso (multi-channel biophysical research recorder (s)), the Electromanometer (for pressure recordings), and other new Sanborn instruments for cardiac and other research, teaching, and diagnosis.

## **SANDOZ CHEMICAL WORKS, INC.**

**Booth No. 3**

Sandoz Pharmaceuticals cordially invites you to visit our display at the Illinois State Medical Convention — Booth No. 3

**CAFERGOT** Available in oral and rectal form for effective control of head pain in migraine and other vascular headaches.

**BELLERGAL** Valuable as an autonomic inhibitor in a variety of functional ills—the volume of favorable clinical report is constantly increasing.

**HYDERGINE** A vasorelaxant with central and peripheral action useful in hypertension and peripheral vascular disorders and geriatric conditions.

**FIORINAL** A new approach to therapy of tension headaches and other head pain due to sinusitis and myalgia.

Any of our representatives in attendance, will gladly answer questions about these and other Sandoz products.

## **W. B. SAUNDERS COMPANY**

**Booth No. 111**

In keeping with the constant changes taking place in medicine, Saunders will again be on hand with many new books on a variety of pertinent subjects. Among them: Nelson's Textbook on Pediatrics; A.M.A. Fundamentals of Anesthesia; and Conant's Manual of Mycology. Latest editions of our standards such as: Cecil-Loeb's Textbook of Medicine; Dorland's Dictionary; Current Therapy 1954; and the Medical, Surgical, and Pediatric Clinics of North America will also be on display.

## **SCHENLEY LABORATORIES INC.**

**Booth No. 19**

**The exhibit features:**

**EDIOL** A palatable oral fat emulsion for quick gain in weight and energy.

**TITRALAC** An effective antacid because it titrates like milk.

**SEDAMYL** A non-barbiturate, ideal for day-time sedation without drowsiness.

**DORBANE** A precise potency for individualized dosage in the treatment of constipation.

**VASCUTUM** Potent lipotropic and capillary protective action against the degenerative diseases of old age.

## **SCHERING CORPORATION**

**Booth No. 57**

SCHERING CORPORATION, Bloomfield, New Jersey (Booth No. 57). Members of the Illinois State Medical Society and their guests are cordially invited to visit the Schering exhibit where new therapeutic developments will be featured.

Schering representatives will be present to welcome you and to discuss with you these products of our manufacture.

## **JULIUS SCHMID, INC.**

**Booth No. 10**

## **G. D. SEARLE & CO.**

**Booth No. 112**

You are cordially invited to visit the Searle booth where our representatives will be happy to answer any questions regarding Searle Products of Research.

Featured will be Vallestiril, the new synthetic estrogen with extremely low incidence of side reactions; Banthine, and Pro-Banthine, the standards in anti-cholinergic therapy; and Dramamine, for the prevention and treatment of motion sickness and other nauseas.

## **SHARP & DOHME**

**Booth No. 98**

The many indications for 'Hydrocortone' or 'Cortone' highlight the therapeutic importance of these hormones in everyday practice. Research data relative to more effective therapy where penicillin is used in conjunction with 'Benemid' probenecid completes the exhibit. Expertly trained personnel solicit discussions on these observations.

## **SHERMAN LABORATORIES**

**Booth No. 65**

**PROTAMIDE:** A sterile colloidal solution of denatured proteolytic enzyme. Published clinical studies have convincingly established Protamide's value in neuritis, herpes zoster and tabes dorsalis.

NOVADONNA: An antispasmodic combining the levorotatory alkaloids of belladonna with homatropine methylbromide for greater spasmolysis and less side-effects.

●  
**SMITH, KLINE & FRENCH LABORATORIES**  
**Booth No. 6**

The S.K.F. booth will feature "Spansule"\* Sustained release capsules—the revolutionary new oral dosage form. Just one 'Span-sule' capsule, taken on arising, provides a uniform supply of medication throughout the day. Thus, 'Spansule' capsules offer you 3 advantages: (1) smooth, uniform action, (2) prolonged therapeutic effect, and (3) convenient once-a-day dosage.

\*SPANSULE — S.K.F. Trademark

●  
**E. R. SQUIBB & SONS, Division of Mathieson**  
**Chemical Corp.**  
**Booths 52 & 53**

●  
**STANDARD AIR SERVICE CO.**  
**Booth No. 96**

Specializing exclusively in room air conditioning for 23 years.

●  
**THE UPJOHN CO.**  
**Booth No. 110**

●  
**U. S. VITAMIN CORPORATION**  
**Booth No. 29**

See the "oil-in-water" demonstration of liposoluble vitamins A and D made completely water soluble... a vitamin technical achievement originated and developed by the U. S. Vitamin Corporation Research Laboratories.

Three pharmaceutical firsts. . . Vi-Syneral Vitamin Drops—multivitamins in drops solution; Vi-Syneral Injectable—multivitamin parenteral solutions and now Vi-Aquamin—aqueous vitamins and minerals in a single capsule.

Exhibit also features original, complete

lipotropic therapy . . . METHISCHOL . . . the combination of five proven lipotropic agents: B<sub>12</sub>, choline, methionine, inositol and liver extract. Therapeutically effective in the treatment of hypercholesterolemia as associated with atherosclerosis, coronary disease, obesity, diabetes and various forms of liver disease, including liver cirrhosis and toxic hepatitis.

●  
**VARICK PHARMACAL CO.**  
**Booth No. 109**

●  
**WALDEN INDUSTRIES, INC.**  
**Booth No. 33**

Simple, automatic, and economical equipment for clinical close-up photography is shown. QUICK-CLIX Projection Bulb and Strobe Outfits feature fully automatic aperture and shutter control mechanisms for finest color or black and white pictures. The low-priced WALCO Lighting Unit utilizes fixed focus applicators to make photography extremely easy for busy practitioners.

●  
**WALTON LABORATORIES, INC.**  
**Booths No. 40 & 41**

Walton will exhibit a complete line of residential, office and hospital humidifiers.

Walton COLD STEAM\* humidifiers are now recommended and used by leading physicians for the treatment of upper respiratory diseases.

\*COLD STEAM — trade mark

●  
**WINTHROP-STEARN'S INC.**  
**Booth No. 5**

●  
**F. E. YOUNG & CO.**  
**Booth No. 9**

●  
**ZEMMER COMPANY**  
**Booth No. 11**

# Twenty-Sixth Annual Meeting

## of the

# WOMAN'S AUXILIARY

## to the

# ILLINOIS STATE MEDICAL SOCIETY

A cordial invitation is extended to all members of the Woman's Auxiliary to the Illinois State Medical Society, and to the wives and guests of physicians attending the annual meeting of the Illinois State Medical Society, to participate in all social functions and attend the general sessions of the Auxiliary.

Headquarters will be at the Hotel Sherman. Tickets may be secured at the registration desk. Please register early and obtain your badge and program.

### REGISTRATION HOURS

#### Lobby Floor

Monday, May 17, 1954 . . 1:00 p.m.—4:00 p.m.  
 Tuesday, May 18, 1954 . . 8:30 a.m.—4:00 p.m.  
 Wednesday, May 19, 1954, 8:30 a.m.—4:00 p.m.

### PRE-CONVENTION SCHEDULE

#### Monday, May 17, 1954

1:00-4:00 REGISTRATION—Lobby Floor  
 2:30-5:00 Pre-Convention Board Meeting —  
 Gold Room, #114 (First Floor)

### CONVENTION PROGRAM

#### Tuesday, May 18, 1954

8:30-4:00 Registration—Lobby Floor  
 9:00 Formal Opening of the Twenty-Sixth Annual Meeting of the Woman's Auxiliary to the Illinois State Medical Society. The Crystal Room, (First Floor)  
 Mrs. Henry Christiansen, Presiding  
 Pledge to the Flag . Mrs. Willis I. Lewis  
 Invocation . . . . Rev. David Engstrom  
 Welcome . . . . Mrs. Eugene McEnery  
 Response . . . . . Mrs. D. C. Good  
 Auxiliary Pledge . . . Mrs. James. P. Simonds  
 Business Session:  
 Credentials and Registration . . . Mrs. Gregory Carey  
 Convention Rules of Order . . . Mrs. A. G. Mohaupt  
 Adoption of Convention Program . . .  
 Appointment of Reference Committees  
 Appointment of Reading Committees  
 Appointment of Committee on Courtesy & Resolutions

Convention Announcements . . . Mrs. B. K. Lazarski  
 Reports of County Auxiliary Presidents  
 Report of President — Woman's Auxiliary

2:30 p.m. Tea and Fashion Show—Lake Shore Athletic Club, Honoring Past State Presidents.

### Wednesday, May 19, 1954

8:30-4:00 Registration—Lobby Floor  
 9:00 Reference Committee 1.—Mrs. E. M. Egan—Parlor L (Mezzanine)  
 10:00 Reference Committee 2—Mrs. Harlan English—Parlor L (Mezzanine)  
 11:00 Reference Committee 3—Mrs. Carl Sibilsky—Parlor L (Mezzanine)  
 Guests are welcome at all Reference Committee meetings.  
 1:30 Second General Meeting—Crystal Room  
 Mrs. Henry Christiansen, Presiding  
 Convention Announcements—Mrs. B. K. Lazarski  
 Credentials & Registration—Mrs. Gregory Carey  
 Report on Revisions Committee—Mrs. Robert Dunlevy  
 Guest Speaker—Miss Emily Cardew, R.N. B.S., M.S., Director, School of Nursing, University of Illinois, Chicago.  
 3:00 Memorial Services—Crystal Room  
 Mrs. Roman Siemens, Conducting

### Thursday, May 20, 1954

9:00 Third General Meeting—Louis XVI Room  
 Mrs. Henry Christiansen, Presiding  
 Credentials and Registration—Mrs. Gregory Carey  
 Report of Reference Committees:  
 Committee 1 . . . . . Mrs. E. M. Egan  
 Committee 2 . . . . Mrs. Harlan English  
 Committee 3 . . . . Mrs. Carl Sibilsky  
 Courtesy and Resolutions—Mrs. Arthur Edison  
 Report of Nominating Committee—Mrs. Henry Schmitz

Election of Officers

New Business

1:00 Luncheon—Assembly Room (Mezzanine Floor)

Honoring Mrs. Henry Christiansen, President, Mrs. A. T. Kwedar, President-Elect

### CONVENTION COMMITTEES

Mrs. B. K. Lazarski—General Chairman

Mrs. E. H. Leveroos—Co-Chairman

### HONORARY COMMITTEE

Mrs. Willis I. Lewis

Mrs. H. Close Hesseltine

Mrs. C. Paul White

Mrs. Eugene McEnery

Mrs. Warner Newcomb

Mrs. F. Lee Stone

Mrs. Arkel Vaughn

Mrs. H. Kenneth Scatlift

Mrs. Frank H. Fowler

Mrs. Walter C. Bornemeier

### REGISTRATION AND CREDENTIALS

Mrs. Gregory Carey—Chairman

Mrs. George L. Pastnack

Mrs. Charles Vil

Mrs. George W. Carlin

Mrs. Garland Brown

Mrs. Leslie J. Heintz

Mrs. Frank Wojniak

Mrs. E. L. Leimbach

Mrs. Charles Spirrison

Mrs. Jacob Marks

Mrs. Harry Petrakos

Mrs. William Herman

Mrs. Charles Krause

Mrs. Maurice Farinacci

### PRESS AND PUBLICITY

Mrs. Nicholas Chester—Chairman

Mrs. Gene Wong—Co-Chairman

Mrs. George Kaiser

Mrs. Patrick McNulty

Mrs. Vaughn Avakian

Mrs. Carl Gast

Mrs. Lars Andrew Dolan

Mrs. George P. Vlasis

### COURTESY AND RESOLUTIONS

Mrs. Arthur I. Edison—Chairman

Mrs. Walter C. Bornemeier

Mrs. James P. Simonds

### TIMEKEEPERS

Mrs. Matthew W. Uznanski—Chairman

Mrs. Thaddeus J. Jasinski

Mrs. A. I. Love

### PAGES

Mrs. T. B. Bondus—Chairman

Mrs. Alex Walker

Mrs. S. A. Lask

Mrs. Joseph Bezdek

Mrs. Joseph Levenson

Mrs. C. W. Scruggs

Mrs. J. A. Lemons

### REFERENCE COMMITTEES

Mrs. A. F. Gareiss—General Chairman

#### Reference Committee I—

##### Reports of Officers & Directors

Mrs. E. M. Egan—Chairman

Mrs. Russell M. Jensen

Mrs. James Patejdl

Mrs. Charles Segal

Mrs. Fred L. Glen

#### Reference Committee II

##### Reports of Standing Committees

Mrs. Harlan English—Chairman

Mrs. H. E. Schoonover

Mrs. William Elghammer

Mrs. John H. Whaley

Mrs. William Raim

#### Reference Committee III

##### Reports of Councilors

Mrs. Carl E. Sibilsky—Chairman

Mrs. B. E. Montgomery

Mrs. Leo L. Grzesk

Mrs. William Rideout

Mrs. Albert C. Maess

### HOSPITALITY COMMITTEE

Mrs. W. Walter Sittler—Chairman

Mrs. Henry Berchtold—Co-Chairman

Mrs. E. H. Blair

Mrs. R. C. Davies

Mrs. Edward Cannon

Mrs. Charles Downing

Mrs. William Borkenhazen

Mrs. William Johnson

Mrs. J. B. Karr

Mrs. John Schilsky

Mrs. William Nainis

Mrs. Edward Ward

Mrs. George Vlasis

Mrs. Walter Shriner

Mrs. William Patejdl

Mrs. R. V. Grimmer

Mrs. J. L. Foley

Mrs. Stanley K. Nord

### HOSPITALITY FOR STATE PRESIDENTS

Mrs. James McDonnough

### MEMORIAL SERVICES

Mrs. Roman Siemens

### LUNCHEON COMMITTEE

Mrs. H. Close Hesseltine—Chairman

Mrs. Leonard J. Houda—Co-Chairman

Mrs. Maurice Hoeltgen—Co-Chairman

Mrs. Ralph P. White

Mrs. Jacob L. Marks

Mrs. William P. Jonas  
Mrs. David Slight  
Mrs. Edward C. Helfers  
Mrs. Lloyd Gittelsohn  
Mrs. L. E. Lundgoot  
Mrs. Hugh B. Fox  
Mrs. L. J. Jurek  
Mrs. Carlo Scuderi

●  
**TEA AND STYLE SHOW**

Mrs. M. M. Hipskind, Chairman  
Mrs. W. W. Young, Co-Chairman

●  
**TICKET COMMITTEE**

Mrs. Edward G. Warnick, Chairman  
Mrs. John Van Prohaska, Co-Chairman  
Mrs. Ralph L. Sullivan

Mrs. Victor Engelmann  
Mrs. Thaddeus Chrzan  
Mrs. J. S. Schriver  
Mrs. Warren W. Furey  
Mrs. Charles Spurrison  
Mrs. Charles McKenna  
Mrs. Henry L. Schmitz  
Mrs. John Wolff  
Mrs. Frank P. Kraft

Mrs. Edward H. Warszewski

Please plan to attend this informative convention, and plan to make your reservations EARLY. Other details in the Illinois Auxiliary News.

Mrs. B. K. Lazarski,  
Convention Chairman  
Mrs. Nicholas G. Chester,  
Press and Publicity-Convention

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## **CANCER AND THE HAIR NET**

To be of any great value (cytologic diagnosis of gastric carcinoma) these tests require the use of the gastric balloon; the patient, after a short fasting period, swallows a sausage-shaped balloon made of thin rubber and covered with an ordinary hair net. This is attached to a double tube, one lumen of which is for introducing and aspirating washing fluid, and the other for inflating the balloon after it has been swallowed. The patient passes this apparatus by swallowing a glassful of Ringer's solution to wash it down. The pharynx may be slightly anesthetized in nervous and apprehensive patients. Once the tube is down, all the contents of the stomach are aspirated through the tube, and the organ is thoroughly washed out. The balloon is then inflated and allowed to be drawn to the pylorus, where it is briefly deflated so that it can enter the antrum. Its position in the stomach is

determined by gauge rings on the tube. The balloon is reinflated and gently drawn through the cardia; the process is repeated five or six times in the course of 15 to 30 minutes, during which the gastric contents are frequently aspirated and collected for centrifugation and smearing. The balloon is then deflated and withdrawn, and its surface inspected for any shreds of tissue, which are removed with a spider forceps and immediately fixed in alcohol and ether. It is then rinsed off into a container with Ringer's solution, and the washings either pooled with the gastric aspirations or kept separate. One then has abraded shreds, gastric washings, and rinsings of the balloon's surface. This technic has been described at some length since it is essential for good diagnostic results. Centrifugates are mixed with alcohol and smeared as usual. *Nathan Chandler Foot, M. D., The Value Of Exfoliative Cytology To The General Practitioner. New England J. Med. Oct. 1, 1953.*

## EDITORIALS



### THE 114th ANNUAL MEETING

The Annual Meeting of the Illinois State Medical Society, will be held at the Hotel Sherman, Chicago, May 18-21, 1954. The program for this meeting is published in this issue of the Illinois Medical Journal. There will be some additions and perhaps a few minor changes which will be published in the official program to be distributed at the meeting.

As will be noted in the program, individual Sections will meet in the forenoon on Tuesday, Wednesday and Thursday, while the afternoons will be devoted to the presentation of general assemblies. On Friday morning scientific movies will be shown for the entire session.

The usual large number of scientific and technical exhibits have been arranged. All section meetings will be conducted on the first floor of the Hotel Sherman. There will be three meetings of the House of Delegates, the first scheduled for Tuesday morning, the second Thursday afternoon, and the final meeting on Friday morning. This arrangement has been made to give delegates a better opportunity to attend more of the general assembly meetings.

The Committee on Credentials will speed up the seating of delegates this year, and its first certification of delegates is scheduled for 8:00 A.M., Tuesday, May 18. Reference Committees will meet on Wednesday to conduct hearings,

then develop their reports to be presented at later sessions of the House.

The Committee on Scientific Work has developed an unusually fine program for the Annual Meeting and it is hoped that the membership will show its appreciation of these efforts by attending this 114th Annual Meeting.

### COST OF POSTGRADUATE TRAINING DEDUCTIBLE

The U. S. Court of Appeals, Second Circuit, in reversing a decision of the U. S. Tax Court recently, held that the expenses incurred by a lawyer in attending a postgraduate course, were deductible for federal income tax purposes. The court held that the knowledge gained through such a course increased the lawyer's fund of learning in general, and also enabled him to perform his related work with due regard to the current status of law. Therefore, the cost of acquiring this education was more than a personal expense.

It is reasonable to assume that this decision will apply to similar expenses incurred by members of the medical profession. The tax counsel for the Bureau of Legal Medicine and Legislation, of the American Medical Association, made the following statement in the October 31, 1953 issue of the Journal:

"The decision of the Circuit Court is not con-

fined to lawyers. It equally applies to the practicing physician who attends postgraduate courses which are similarly designed to refresh his medical knowledge and to keep him informed of recent medical developments. Therefore, in computing his federal income tax a doctor may deduct the expenses of his attendance, namely, the cost of his tuition, travel, board, and lodging. However, it is by no means clear that the court's decision covers attendance at postgraduate courses which are designed to advance the doctor into a new area of his profession. For example, there is a good deal of doubt whether a general practitioner may deduct his expenses in attending a postgraduate course in order to specialize in surgery. But this would be the unusual case. Normally, a doctor attends a postgraduate course relevant to the field in which he is practicing and all the expenses which he so incurs are deductible by him."

Refresher courses and educational endeavors that pertain to the special field in which the physician is engaged, should come under this category.

## UPLIFTING THE BREAST

Reconstructive surgery on the small breast made headlines in *Pagant* last year when a west coast surgeon, with a Hollywood number in telephone books of several cities in the country announced a simple, 25 minute procedure. The idea was good but follow-up reports by other plastic surgeons demonstrated that the announcement was premature.

The surgeon in question had elevated the breast and stuffed the area to eliminate the sag, with a nylon-like, resilient material impregnated with penicillin. A group from the American Society of Plastic and Reconstructive Surgery discovered later that nine out of 16 known cases encountered a violent foreign body reaction, with expulsion of the substance. Some of the filling became foul and gristly within three weeks after its insertion.

This experiment demonstrates that reconstructive surgery is a more technical problem than the simple insertion into the space between the breast and ribs of an inert, soft substance. Many previous attempts have been made with metal plates, wire mesh, acrylic molds, ivory, paraffin, bone, and cartilage but results were not uniformly successful. In some they were

pitiful and were followed by malpractice suits.

The use of a polyvinyl sponge is the most recent innovation. Several reports from reputable investigators have appeared but the comments by Pangman, of Beverly Hills, are discouraging. He found that in 25 per cent, drainage took place; in 10 per cent it was so profuse the "stuffing" had to be removed. In addition, the sponge shrunk by 25 to 50 per cent and it had a tendency to become hard and lumpy. Pangman developed a new compound prosthesis with an outer shell of polyvinyl and an insert of the same material covered by an airtight plastic film and sterilized by vacuum and gas. This new insert has been used in over 100 cases, including several mastectomies, and slight drainage occurred only in four. Time will tell whether the reconstruction will be a success.

In a recent article in *Science*, Oppenheimer, and others reported the production of cancers around bits of plastic they had inserted into rodents. Following implantation of 11 different types of plastic, tumors developed in every instance, many of which were malignant.

In this era of the "falsie," no one knows better than the medical profession that breast plasty represents an obvious need. The procedure must be safe to withstand the test of time. If rodents encounter malignancies after a year or two, will humans be affected similarly in a decade or two?

## COGITATIONS ON SPHYGMOMANOMETRY AND HYPERTENSION

It is to be expected in a subject as abstruse as medicine we are still ignorant of the basic causes of some pathological conditions. Hypertension is an example. As early as 1733 that inventive genius Stephen Hales did experimental work on the physiology of blood pressure, and later Magendie and Poisseuille, still later Carl Ludwig and Newell Martin, extended our knowledge of the subject. It was not until the early part of the present century however, that observations on the blood pressure of the sick became routine, and though some observers were using the instruments employed in modern sphygmomanometry before Theodore Janeway's book on blood pressure was published in 1904, that work had a marked influence in educating the profession as to its importance.

There is, of course, no doubt that some acute

clinicians had observed variations in the digital compressibility of the pulse in various diseases long before the advent of accurate instruments. Indeed in his youth the writer recalls that W. S. Thayer, then Doctor Osler's resident, delighted in comparing his palpatory estimates of blood pressure with instrumental readings and was often surprisingly close to the correct record. While the early experimentalists used mercurial manometers as recorders, the invention of the modern cuff must be credited to the Italian clinician Scipione Riva Rocci who first used a small digital cuff and later the broad arm cuff. The latter was introduced into this country by Harvey Cushing who had seen it in use in Riva Rocci's Clinic, and it is interesting to note that surgeons, particularly Harvey Cushing and George Crile, were among the first to make extensive use of blood pressure determinations. The original Janeway sphygmomanometer had a very long glass tube to contain the mercury, the upper half detachable, which registered up to 300 millimeters. On one occasion the writer recalls blowing the mercury out at the top, the patient an elderly lady, having a systolic blood pressure over 300. She lived three or four years after this incident. The introduction of mechanical devices for registration facilitated carrying the instrument in the doctor's bag, and the auscultatory rather than the palpatory reading of blood pressure made for greater accuracy.

It is to some extent up to the clinician to decide whether a patient really has hypertension. Strictly speaking there is no such thing as a normal blood pressure, the variability of human beings precludes this. It is doubtless necessary for Insurance Companies to set up standards for practical purposes, but we must not forget that these are merely averages and that the arterial tension in some healthy people may vary from such criteria to a considerable extent. This situation is further complicated by the well-known fact that real hypertension may be asymptomatic for long periods.

As to classification of hypertension, it is clear that in some patients it is secondary to other diseases. It may occur as a result of some forms of Bright's disease, with unilateral nephropathy, with tumors of the adrenals, with Cushing's syndrome, and with various other dis-

eases including atherosclerosis, which last association may however be the result of what Winston Churchill termed "the long arm of coincidence."

The very term *essential* hypertension indicates an unknown pathogenesis, for essential is merely an alias of our old friend idiopathic. There is some evidence suggesting a possible family predisposition to the condition, and there is no question that the disease may run a malignant course, killing the patient in a few years, usually from nephritic, cardiac or cerebral complications. It is perhaps not sufficiently realized how long patients with the milder type may survive. Doctor Joseph H. Pratt has recently reported a fifty-year blood pressure record in a patient with this type, (Foot Note—Bull. New England Med. Center, 1953, 15, 156) and Doctor Samuel Proger (Foot Note Loc. cit. p. 125) has ably discussed the prognostic criteria of the malignant type, the most important consideration being sex, level of blood pressure and, above all, the tempo of progress. The subject is one constantly under study and no doubt the pathogenesis will be revealed in time. G.B.

## MEDICINE IN CHICAGO IN THE '80's

Frederick Stenn, M.D.

Chicago

Amongst the correspondence of the late Dr. Ludvig Hektoen\* appears the following letter: "My dear Hektoen:

About 15 minutes after reading yours of the 25th inst., the hired girl brought in the February issue of the Arch. of Pathology. Have just finished reading your paper. Great as we all thought Fenger was, we are still discovering that he was still greater. (Christian Fenger, (1840 - 1902) is far and away the most important figure in the history of Chicago medicine). You, of course, recall the wonderful banquet that was tendered him years ago. I can never forget how proud I was when someone told me that when he, that is Fenger, was asked to give a list of names of those he would like to see there, he gave my name. Sixty-eight years old, lying in bed, permitted to see but few people, I know you will pardon me if I become talkative and reminiscent.

I attended the old P. & S. (College of Physicians & Surgeons of Chicago, opened 1882)

\*Private correspondence of Dr. Ludvig Hektoen — John Crerar Library, Chicago.

session of '83 and '84, then had to work a while and in the spring of '85 I got a job of druggist in the dispensary and had a room in the college building which gave me access to microscopes. I became greatly interested in mounting the beef-steak razor slices of tissue under the direction of poor old Dr. Fenger. (The improved microtome was constructed in 1881 in Heidelberg by Jung.) At the beginning of the fall term, Ohlmacher took charge of work. He taught us to stain in block, imbed in paraffin and cut with microtome. (Paraffin embedding emanated from the laboratory of Edwin Klebs in 1869.) I can never forget the thrill I got when I first saw the nests of epithelial cells. I mounted large numbers of slides and traded 500 of them to an instrument house for a 3rd microscope.

During this term I first met Fenger and made arrangements to make slides of tissue that he removed at his clinic and on Monday night took them to his residence on Ohio street where he examined them with his little old microscope that did not have a finger adjustment. If the tissue was found to be a carcinoma he would say "This is your kind, Earle." I have a lot of slides which bear his name because I wanted them to show that he diagnosed them. I always went alone this first (year?). He usually served a little wine and cookies. You will recall that later on the internes went, too. During this year '85 and '86 I cut a lot of specimens for McDill and other internes in C. C. H.

Early in '85 there was a woman coming to the dispensary with active T. B. I tried again and again to find T. B. in her sputum but couldn't do it. (The tubercle bacillus was dis-

covered in 1882 by Robert Koch) I mentioned my poor luck to Fenger. He said "Go and see Gradle. (Henry Gradle, 1856-1911). He'll show you." I went down to his office. Such a pleasant kindly little fellow. It didn't take him long to stain a slide and demonstrate it. I rushed over to C.C.H. and showed it to the internes. I am not so sure but I believe it was the first that the internes had seen. I am constrained to believe this because Caldwell (Chas. A. Caldwell) went into the hospital in 1885 and I had met him often and he knew how hard I had worked without success until I saw Gradle. I remember he complimented me for my persistence and final success. I was so elated that I thought of advertising that "for \$1.00 I could tell with certainty whether a person had T. B. or not."

Of course, it is usually conceded that Belfield (Wm. T. Belfield) was first to bring Koch's Carbol Fuchsin stain to Chicago, perhaps to the U. S. It would be interesting to know when and how Gradle got it and why Fenger sent me to Gradle instead of Belfield. However, if you start to write the history of T. B. and who first stained T. B., the time of Christ will be a late date and the woods in and around Chicago would be found full of fellows (of course more modest than I am) who antedate my work. . . . I just dread the days and nights too. They're so long. To be sick graciously is an art that I haven't acquired. What would I do if I couldn't read?

Sincerely,  
C. A. E."

(C. A. Earle  
1862-1938  
DesPlaines, Ill.)

# MEDICAL ECONOMICS

**The Medical Economics Committee. John R. Wolff, Chairman, Walter C. Bornemeier, Edward W. Cannady, Roland R. Cross, Jr., E. F. Dietrich, W. W. Fullerton, Edwin F. Hirsch, Frederic T. Jung, W. R. Malony, Caesar Portes, William Requarth, Frederick W. Slobe.**



## The Need for Revision of the Coroner's Act

**Edwin F. Hirsch, M.D.  
Chicago**

Two systems for the medicolegal investigation of deaths by violence or unnatural causes are in use in this country. The first and most prevalent is the archaic office of the Coroner, introduced from Great Britain during the colonial period. The Coroner is elected to office by his political constituency without requirements of professional qualifications. In many counties of Illinois the Coroner is a political aspirant engaged in some local business enterprise or occupation. It is entirely possible that a physician or a lawyer be elected to serve as a Coroner, but this is the exception, and most Coroners are not competent in either pathology or law.

A coroner in establishing the cause and circumstances of a death by violence should have the facts which only a careful and complete necropsy discloses. As a layman he is not qualified to obtain this information directly but must gain it through a physician. Although a physician is registered to practice medicine in Illinois he is not necessarily skilled in pathological anatomy as it is applied in the field of medicolegal practice. Many pertinent conclusions of the

manner and circumstances of death become apparent to a pathologist trained in this specialized practice. With many cases of real or suspected homicide great skill is necessary to obtain satisfactory evidence of guilt and to present it in court convincingly. The technic of obtaining evidence must be so organized that the best methods are used by the law enforcement bodies to clear innocent homicide suspects or to bring the true offender to justice. Personnel trained in the fields of chemistry, ballistics, graphology and many of the basic biological sciences are required to uncover facts which incriminate and later convict these violators of criminal law.

The use of such a system of experts is not the practice among Coroners in the State of Illinois. At the inquest which the present law provides, the coroner or his untrained politically appointed deputy, attempts to obtain from an equally, poorly qualified jury of six men, a verdict as to the manner and means of death. This phase of the investigation becomes farcical because none of the participants, as a rule, has legal or medical qualifications. The Coroner, according to the

statute, also has the power of a sheriff.

In the second or medical examiner's system, the coroner's office is abolished or redefined so that the important legal duties of the office are taken over by the existing law enforcement agencies, and the medical investigation is made by an experienced pathologist, trained in the application of this specialty in establishing the cause of deaths by violence. The medical examiner's systems of Boston, New York City, Essex County of New Jersey, the Commonwealth of Virginia, the State of Maryland and elsewhere use toxicologists, crime detection laboratories, immunologists, anthropologists and other experts in the investigation of these deaths and also in crimes of lesser degree than murder in which medical sciences can aid in criminal investigations. The evidence obtained through the medical examiner's system is referred directly to the States Attorney or District Attorney for legal procedures.

In May 1952, the Council of the Chicago Medical Society and the House of Delegates of the Illinois State Medical Society unanimously passed the following resolution:

WHEREAS, the office of Coroner, as it now exists in Illinois, and in most of the other states, has become completely outmoded, and is not equipped to effectively or efficiently discharge the important legal and scientific functions with which it is primarily concerned; and

WHEREAS, because of the many inadequacies of the Coroner system, scientific medicine contributes less to the administration of justice in the United States than in any comparable country in the world; and

WHEREAS, the ineffective and wasteful manner in which scientific medical knowledge and skill are utilized in the administration of justice in Illinois, under the archaic Coroner system, predisposes to the nonrecognition of murder; the unjust accusation of innocent persons, the inadequate or erroneous evaluation of medical evidence surrounding fatal injuries, the failure to acquire medical evidence which would be useful in the apprehension of criminals, the failure to acquire medical evidence essential to the administration of civil justice, the ignorance of certain otherwise preventable hazards to public health and the impairment of the value of vital statistics; and

WHEREAS, no sustained effort has been made in Illinois to modernize the functions and activities of the office of Coroner, although from time to time sporadic interest has been exhibited in the subject by various individuals, groups and agencies; therefore, be it

RESOLVED, that the Council of the Chicago

Medical Society hereby reaffirms its continuing interest in the efficient and effective administration of justice for all of the citizens of Illinois; in the intelligent use of modern medical skills and scientific methods in all criminal investigations; and in the enactment or revision of such laws as may be necessary to modernize the functions and duties of the Coroner of this State, and to bring to that office the same high level of efficiency attained in those cities and states which have a medical examiner's system, rather than a Coroner; and be it further

RESOLVED, that the House of Delegates of the Illinois State Medical Society be urged to adopt a strong position in favor of modernization of the Office of Coroner, and to seek the cooperation of the Illinois State Bar Association, through a joint committee to be established for that purpose, to make a careful study of the shortcomings of our Coroner system, and to recommend such legislative action as may be appropriate to rectify them; and be it further

RESOLVED, that this resolution be presented for adoption by the House of Delegates of the Illinois State Medical Society.

Throughout most of the United States and specifically in the State of Illinois inquiry into the cause of violent death and death from obscure causes is done by laymen or physicians who lack the experience and technical aids necessary to establish the true cause and manner of death. Any state is best served by a medico legal laboratory staffed by experts who are continually becoming more experienced. The man trained in legal medicine is more reliable than the occasional and inexperienced investigator. This system can be realized by having a central nucleus of competent experts who respond when alerted by regional investigators. The organization of such a system requires time for development and training. The first step in this direction is a revision of the Coroner's Act in the State of Illinois.

A Bill prepared for the last session of the Legislature of the State of Illinois proposed a revision of the laws in relation to coroners. The bill provides more efficient scientific and legal procedures for public safety and criminal justice in cases of real or suspected unnatural death. The bill does not abolish the Coroner's office but defines its functions, whereby the archaic coroner system is replaced by the more efficient Medical Examiner System. It provides the appointment by the County Board of a Chief Medical Examiner and as many assistants as are necessary, and it specifies that the Chief

Medical Examiner shall have at least 2 years of specialized training in pathology, more specifically necropsy experience. It abolishes the practice of having inexperienced politically appointed physicians do the necropsy examination, and 2) the cost of coroner's juries which function simply as a lay group. It opens a direct approach to the use of crime detection procedures and laboratories. The information thus obtained is processed into the States Attorney's office.

The recent procedures used by the Coroner of Cook County in the case of Laura Lingo\* is a specific example of ineptness that should arouse the physicians of the State of Illinois and others to demand a revision of the Coroner's Act.

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\*Bulletin Chicago Medical Society 56: 666-668 (No. 34) Feb. 20, 1954.

## PENICILLIN IS FIRST

Today, because of the wide therapeutic effectiveness of the antimicrobial agents, most infectious diseases are treated successfully at home. No doubt the accuracy of future medical literature dealing with infectious diseases will depend largely upon those who see the patient initially and record not only the disease but the action of the drugs employed. It is for this reason that the practicing physician is in an enviable position to record such facts, which greatly adds to the stock of common knowledge. One should reserve the use of these agents for the treatment of serious infections and restrict their prophylactic use to those conditions in which the complication to be avoided is a serious one and one which occurs frequently in the absence of precautions. Furthermore, one should use doses of single agents that have proved adequate and effective and reserve the use of multiple agents for the type of case in which there is already adequate proof that their use may be expected to yield beneficial effects. Penicillin by virtue

of its antibacterial action remains the most effective antibiotic against the majority of bacterial infections, and since it is the least expensive and toxic, it is the drug of choice for most of the infectious diseases encountered in this part of the world. Certainly, very few lives will be lost by employing penicillin initially, and if subsequent studies so indicate, then another agent, or agents, may be substituted. When one considers the untoward reactions associated with these agents, it is essential that the physician who undertakes to prescribe these drugs shall exercise the same caution as when he administers any other highly useful but potentially dangerous drug. Finally, despite the proved prophylactic and therapeutic effectiveness of the antimicrobial agents, it is to be remembered that they are not to be used to the exclusion or neglect of other proved forms of therapy. *Harrison F. Flippin, M.D., Philadelphia, Pa., Antibiotogenic Syndromes, N. Y. State J. M., December 15, 1953.*

# THE P.R. PAGE



## WASHINGTON SPEAKS

Frank E. Wilson, M.D., director of the Washington office of the American Medical Association, will be the principal speaker at the annual P. R. dinner this year.

It will be held Tuesday night, May 18, in the Hotel Sherman, during the annual meeting of the state society.

Invitations will be mailed well in advance, giving program details, together with return postcards making reservations.

## SUGGESTION FOR SECRETARIES

A recent survey by Medical Economics (February 1954) indicates that about a third of the nation's physicians are not members of organized medicine, of whom about 40% are on the outside by choice.

If medicine's views are to carry political and public relations weight, unity and a much higher percentage of membership is essential.

That 40% therefore represents an opportunity and a challenge for many county societies to add to their membership rolls and help solidify medical opinion behind medical leadership. That does not, of course, refer to license-holders who are not qualified or who have proven unworthy of admission, but to the approximate 14% of all physicians who refuse to seek membership

in organized medicine.

These men should be sought out to learn their reasons for not filling out a membership application. There is an answer to each of the usual reasons for remaining aloof as listed in Medical Economics, and it is probable that many of these men can be persuaded to join or to resume membership.

A study of the Medical Economics report and a well-planned campaign to identify and answer objections might increase membership substantially in counties, usually the larger ones, where most of the non-joiners are found.

## P.R. AND THE PRESS

Here are a few tips on good press relations culled from "Your Public Relations," a volume published in 1948, still good, and highly applicable to medical P.R.:

"The open-door press policy is by all measures the best and most satisfactory in the long view."

"Good press relations depend directly on the attitude of every single person who may have any contact with the press."

Some errors to avoid:

"Do not assume that good press and public relations are controlled by a faucet to be turned off or on at will or whim."

"Do not expect your P.R. officer or the reporter

whom you contact to make up for mistakes or deficiencies of your own making."

"Above all, do not assume that you know more about readers' interests than the editor."

### THE BRICKER AMENDMENT ISSUE

The question is still being asked by physicians why organized medicine is supporting, if only in principle, the Bricker Amendment. So perhaps a repetition of the reason is in order. (Word from Washington is that the issue will be revived soon, despite the recent one-vote defeat.) Here it is in brief:

The International Labor Office is an agency established in the League of Nations by Part XIII of the Treaty of Versailles in 1919, which was taken over as a "specialised agency" in 1945 by the United Nations. It thus ranks with UNESCO, WHO and other agencies of U.N. It has its office in Geneva. Each participating government names to it delegates representing labor, management and government. Governments have 50% of the voting strength and labor and management each 25%. Most government delegates vote with labor.

The ILO works by making long studies of various labor problems in all countries, then drawing up a "convention" designed to correct all the "Social evils" found.

When a "convention" is approved, it is sent to all participating governments for action. None can be forced on the nation, but each is obliged, under its agreement, to bring the convention before its governing body for acceptance or rejection.

"And once a country has ratified a convention," the ILO's official history says, "it would be required to give effect to it and to submit reports on the way in which it was doing so."

In other words ratification of a "convention" gives it the force of a treaty, binding on the country like any other international agreement. Such "conventions" can be — and have been — voted into effect, as written, by one vote in a minority session of the Senate.

June 4, 1952, the ILO adopted its Convention No. 102, known as the Social Security (Mini-

mum Standards) Convention, which wrapped up in one package the whole Socialist scheme of so-called "social security," including compulsory government health insurance, unemployment injury benefit, and all the rest.

These comprise the socialized medicine plot medicine has been fighting for several years.

Isn't that reason enough for insisting that such agreements be subjected to full dress debate and a recorded vote, and to all our other protections against a sneak vote to make America Socialist? That is what the principle of the Bricker Amendment would provide and why all good American physicians should support the amendment proposal, now and forever.

For data on corroborating documents, write the Illinois State Medical Society's Committee on Medical Service and Public Relations, Room 902, 185 North Wabash Ave., Chicago 1.

### COUNTY P.R. ACTIVITIES

Knox County has joined the parade of Illinois societies which have undertaken public education programs. Dr. M. C. Beecher, Galesburg, president, reported that the P.R. chairman, Dr. Charles A. Ross, opened it with a discussion of safety and emergency medical service over WGIL, Galesburg. The script shows a medically sound discussion of emergency care and it was well-received locally.

Winnebago, meanwhile, is still receiving compliments for some of its recent programs on obesity and sight-screening, both done in conjunction with public health or school heads over WROK and WTVO respectively. The TV show, in which sight-screening devices were demonstrated on a child, was especially successful.

The show was well-promoted by the Winnebago society, Douglas A. Thorsen, executive secretary, reports. Special mailings to members and other interested parties were done and each school was given a mimeographed slip describing the show, to take home to parents. The script showed how the screening program reaches every child every two years, but only picks up those whose sight is deficient, and it urged annual examination by a physician.

# CORRESPONDENCE



## THE ILLINOIS SOCIETY OF ANESTHESIOLOGISTS

Annual Meeting. Sunday, May 16, 1954  
Sherman Hotel, Randolph Street at Clark,  
Chicago 1, Illinois

The Old Chicago Room, No. 101

### PROGRAM

- 9:00 A.M. "Anesthetic Emergencies" — *Paul H. Loran, M.D.*, Professor and Director of Anesthesiology, University of Kansas, Medical Center, Kansas City, Kansas
- 9:30-9:40 Discussion
- 9:40-9:50 "Chlorpromazine in the Management of Carcinoma Pain" — *Myron Levin, M.D.*, Oak Park, Illinois
- 9:50-10:00 "Hypothermia" — *W. O. McQuiston, M.D.*, Peoria, Illinois
- 10:00-10:10 Discussion of last two papers to be opened by *John W. Pender, M.D.*, Mayo Clinic, Rochester, Minnesota
- 10:10-10:20 Recess
- 10:20-10:50 "The Present Status of New Anesthetic Drugs" — *O. S. Orth, M.D.*, Professor and Director of Anesthesiology, University of Wisconsin, Madison, Wisconsin
- 10:50-11:10 Discussion to be opened by *Carl C. Pfeiffer, M.D.*, Professor and Head of the Department of Pharmacology, University of Illinois, Chicago, Illinois

11:10-11:20 "Sodium Pentothal in Caesarean Section" — *Morris J. Finer, M.D.*, Brookfield, Illinois

11:20-11:30 "A Modification of the Size Technic for Spinal Anesthesia" — *Joseph M. Donnanville, M.D.*, Alton, Illinois

11:30-11:40 Discussion of last two papers

11:40-11:50 "The Organization of an Anesthesia Group in a Medium Sized Metropolitan Area" — *Bryce K. Ozanne, M.D.*, Moline, Illinois

11:50-12:00 noon Discussion to be opened by *Harold Harris, M.D.*, Evanston, Illinois

Noon Recess

2:00-2:30 p.m. "Cortisone and Related Drugs and Their Relationship to Anesthesiology," *John W. Pender, M.D.*, Mayo Clinic, Rochester, Minnesota

2:30-2:40 Discussion to be opened by *Edward Rosenberg, M.D.*, Michael Reese Hospital, Chicago, Ill.

2:40- Annual Business Meeting.  
*Herman J. Nebel M.D.*, President  
*Bernard Stodsky, M.D.*, Secretary  
*H. Livingston M.D.*,  
Chairman of Program Committee  
5805 Dorchester Ave.,  
Chicago 37 Ill.

## CLINICS FOR CRIPPLED CHILDREN LISTED FOR MAY

Twenty-four clinics for Illinois' physically handicapped children have been scheduled for May by the University of Illinois Division of Services for Crippled Children. The Division will count 19 general clinics providing diagnostic orthopedic, pediatric, speech and hearing examinations along with medical social and nursing services. There will be 4 special clinics for children with rheumatic fever and 1 for cerebral palsied children.

Clinics are held by the Division in cooperation with local medical and health organizations, both public and private. Clinicians are selected among private physicians who are certified Board members. Any private physician may refer to or bring to a convenient clinic any child or children for whom he may want examination or may want to receive consultative services.

The May clinics are:

- May 4 — Casey, High School
- May 4 — Pittsfield, Illini Hospital
- May 5 — Hinsdale, Hinsdale Sanitarium
- May 5 — Shawneetown, Stanelle Medical Center
- May 6 — DuQuoin, Marshall-Browning Hospital
- May 11 — Aurora, Copley Memorial Hospital
- May 11 — East St. Louis, Christian Welfare Hospital
- May 11 — Peoria, St. Francis Children's Hospital
- May 12 — Joliet, Will County T.B. Sanitarium
- May 13 — Elmhurst (Rheumatic Fever), Memorial Hospital of DuPage County
- May 13 — Monticello, Lincoln School
- May 13 — Springfield, St. John's Hospital
- May 14 — Chicago Heights (Rheumatic Fever), St. James Hospital
- May 19 — Alton, Alton Memorial Hospital
- May 19 — Evergreen Park, Little Company of Mary Hospital
- May 20 — Macomb, St. Francis Hospital
- May 20 — Rockford, St. Anthony's Hospital
- May 21 — Evanston, St. Francis Hospital
- May 25 — East St. Louis, St. Mary's Hospital
- May 25 — Effingham (Rheumatic Fever), Douglas Township Building
- May 25 — Peoria, St. Francis Children's Hospital
- May 26 — Springfield (Cerebral Palsy), Memorial Hospital

May 27 — Bloomington, St. Joseph's Hospital  
May 28 — Chicago Heights (Rheumatic Fever), St. James Hospital

## ILLINOIS TUBERCULOSIS ASSOCIATION MEETING

The annual meetings of the Illinois Tuberculosis Association and Illinois Trudeau Society Will be held April 29-30, 1954, at the Pere Marquette Hotel, Peoria, Illinois.

Mark Harrington, president of the National Tuberculosis association from Denver, Colorado, will keynote the two day sessions in his address Thursday morning, "Keeping Pace with Changing TB Problems." Arthur S. Webb, M.D., Glen Ellyn, will moderate a panel of citizens following this concerning "Has the General Public Kept Pace with the Changing TB Problem?"

Clarence W. Kehoe, Christmas Seal Sale Director of the National Tuberculosis Association in New York, will address the group at an April 29th session concerning Seal Sale. Legislation in tuberculosis control will also be headlined at a general session on this day. A panel of physicians and lawyers: Dr. Jerome Head, Chicago; Dr. Clifton Hall, Springfield; Charles Scholz, Quincy; Dr. Robert Sutton, Peoria; Clifford Blunk, Springfield; and Senator George Drach, Springfield, will discuss, "Keeping Pace with Legal and Legislative Problems in the Changing TB Problem".

Dr. Frank Coburn, psychopathic hospital, State University of Iowa, will be the annual banquet speaker on April 29.

A combined meeting of the ITA and Illinois Trudeau society on April 30, will feature "Follow Up on Positive Survey Films, TB, Cancer, Etc." and "Keeping Pace with Rehabilitation and the Changing TB Problem".

An afternoon session, April 30, of the Trudeau society, will find these subjects under discussion: "Keeping Pace with Present Trends in TB Therapy", Dr. Hiram Langston, Chicago; Dr. John S. Harter, Louisville, Kentucky, and Dr. M. R. Lichtenstein, Chicago, participants. "Roentgenological Problems in Diseases of the Chest", an x-ray conference moderated by Dr. Hiram Langston, Chicago. Six physicians will present one or more cases each.

The Friday ITA session will concern "Is

Patient and Family Education Keeping Pace with the Changing TB Problems?" Concluding this session will be Ellsworth R. Thwing, assistant executive director of the Illinois Tuberculosis Association. Mr. Thwing will address the group on "Informing the Public About the Unfinished Task in TB Control".

Anyone interested in Tuberculosis control is invited to attend the annual session.

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### **LILLY MAKES RESEARCH GRANTS**

Grants to support research projects being conducted in eleven universities were announced recently by Eli Lilly and Company. Among institutions benefiting from the Lilly grants were the Universities of Chicago, and Illinois.

The individuals receiving the grants and the subjects of their research are as follows:

University of Chicago: Dr. Clayton G. Loosli, department of medicine; study on the use of tissue culture for the isolation of respiratory disease viruses.

University of Illinois: Dr. Robert M. Kark, professor of medicine, College of Medicine; renewal of grant for study of carnitine metabolism at Presbyterian Hospital, Chicago.

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### **AMERICAN ASSOCIATION FOR CLEFT PALATE REHABILITATION**

The annual meeting of the American Association for Cleft Palate Rehabilitation will be held at the Webster Hall Hotel in Pittsburgh, Pennsylvania, Friday and Saturday, May 14 and 15. The program will include special sectional meetings in the areas of medical-surgical problems, dental-prosthetic-orthodontic problems, and speech - psychology - education - social work. Motion pictures and special exhibits relating to cleft palate rehabilitation will be shown throughout the convention. The meeting will be open to any individual with an interest in cleft palate rehabilitation. Further information about the program may be obtained from Dr. S. M. Dupertuis, 3700 Fifth Avenue, Pittsburgh, Pennsylvania.

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### **LOW SODIUM DIET LECTURES**

If you have patients on a *low sodium* diet, perhaps you would like to suggest they, or those

who prepare their meals, attend a series of four lectures and demonstrations to be held in the Auditorium of the Peoples Gas Building, 122 South Michigan Avenue at 2:00 p.m. April 21 and 28, and May 5 and 12.

Please furnish each person intending to be present with your written referral. No reservation necessary. Sponsors: Chicago Heart Association, Chicago Dietetic Association, Chicago Home Economics in Business, and Chicago Nutrition Association.

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### **NURSES' EMPLOYMENT STANDARDS**

The Illinois State Nurses' Association, as a constituent member of the American Nurses' Association, promotes an Economic Security program for its members. One part of this program is the writing and publication of recommended minimum employment standards for the nurses in each of the various branches of nursing. These standards are approved by the Board of Directors of the Illinois State Nurses' Association before they are published.

The employment standards for office nurses are now ready for distribution. Any doctor who wishes a copy may secure one by writing or calling the Illinois State Nurses' Association, 8 South Michigan Avenue, Chicago 3, Illinois. CE 6-9708.

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### **AMERICAN BOARD OF OBSTETRICS AND GYNECOLOGY**

The Directors of the American Board of Obstetrics and Gynecology wish to express their thanks for the many physicians who responded so willingly to their request for help in proctoring the recent written examinations on Friday, February 5, 1954. Those from Illinois who assisted in this work are F. H. Falls, Chicago, Carl Greenstein, Champaign and Paul A. Raber, Decatur.

The next scheduled examinations, Part II (oral and pathological) for all candidates will be held at the Edgewater Beach Hotel, Chicago, May 10 to 17, 1954. Formal notice of the exact time of each candidate's examination will be sent to him several weeks in advance of the examinations. —Robert L. Faulkner, M.D., Secretary, 2105 Adelbert Blvd., Cleveland 6, Ohio.

# NEWS OF THE STATE



## CLINTON

**New Officers.**—Dr. E. C. Asbury, New Baden, was chosen president of the Clinton County Medical Society at its meeting January 13. Other officers are: Dr. R. D. Roane, Carlyle, vice president; Board of Censors, Dr. Fred Pulgram, Trenton, three year term; Dr. W. R. Ketterer, Breese, two year term; Dr. A. L. Fischer, Hoffman, one year term; Delegate to attend State Medical Society, Dr. E. C. Asbury and Alternate, Dr. J. Q. Roane.

**Society News.**—Dr. Willis I. Lewis, Herrin, president of the Illinois State Medical Society, addressed the Clinton County Medical Society recently on "Carcinoma of the Bladder." Miss Kathylin Vercilino, newly appointed county nurse also reported on her activities.

## COOK

**Physicians Named to Newly Created Professorships.**—Two University of Chicago physicians have been appointed to "named professorships" honoring distinguished Chicagoans, according to an announcemet from Chancellor Lawrence A. Kimpton. Dr. Walter L. Palmer, one of the eight original faculty members of the twenty-six year old medical center now at the University of Chicago, was named the Richard T. Crane professor of medicine, and Dr. William E. Adams, the James Nelson Raymond and Anna Louise Raymond professor of surgery.

The Crane professorship, set up by Charles R. and Richard T. Crane, Jr., was established as a tribute to their father who rose from a machinist apprentice earning \$2.50 a week to the head of a multimillion dollar industry, the Crane Company. The surgery professorship honors the late James Nelson Raymond, organizer of the Ray-

mond Lead Company and the United Lead Company, which later merged with the National Lead Company, and Mrs. Raymond, Chicago, philanthropist. Dr. Palmer, an authority on gastrointestinal diseases, has been honored with numerous offices in various organizations concerned with his specialty. Dr. Adams, internationally known chest surgeon who developed new techniques in thoracic surgery, has been honored with similar recognition.

**Dr. Reichert Heads Wesley Pediatric Staff.**—Dr. John L. Reichert has been appointed chairman of the department of pediatrics of Wesley Memorial Hospital, newspapers reported March 6. Dr. Reichert, who is a former president of the Chicago Pediatric Society and of the Illinois Chapter of the American Academy of Pediatrics, is currently assistant professor of pediatrics at Northwestern University Medical School and a member of the staff of Children's Memorial Hospital.

**Marie Hinricks Directs Health Services.**—Dr. Marie Hinricks, associate professor of physical education at the University of Illinois, has been appointed director of health services for the board of education. Dr. Hinricks fills the vacancy left by the resignation of Dr. Kenneth Nolan.

**Branch Meetings.**—The North Shore Branch to the Chicago Medical Society was addressed recently at its dinner meeting in the Edgewater Beach Hotel by Dr. Danely P. Slaughter on "Cancer Characteristics", and Mark C. Wheelock, on "Laboratory Aids in Cancer." The North Suburban Branch was addressed recently by Dr. James R. Dillon, Evanston, on "Preliminary Survey of Repeat Cesarean Sections," and Dr. Wesley W. Spink, Minneapolis, on "Criteria for Selective Therapy in Infectious Diseases."

**Hektoen Lecture Commemorates Centennial of Birth of Paul Ehrlich.**—Dr. Charles Davidson May, chairman of the department of pediatrics, State University of Iowa College of Medicine, Iowa City, delivered the Hektoen lecture of the Institute of Medicine of Chicago at a meeting in the Drake Hotel March 16. The program, sponsored jointly by the Institute and the Chicago Pediatric Society, marked the centennial of the birth of Paul Ehrlich. Dr. Hans C. S. Aron, emeritus associate professor of pediatrics, Northwestern University Medical School, discussed "Dr. Ehrlich's Contribution to Pediatrics."

**New Head of Presbyterian Hospital.**—Dr. Karl S. Klicka has been appointed hospital director of Presbyterian hospital, according to an announcement by Franklyn B. Snyder, president of the board of managers. Dr. Klicka, who has resigned as director of St. Barnabas Hospital, Minneapolis, will take the new office May 1. Dr. Klicka, who received his M.D. from Western Reserve University School of Medicine, Cleveland, also has a degree in hospital administration from the University of Chicago. Previous to his Minneapolis position, Dr. Klicka served as director of Woman's Hospital, New York.

**Grants in Aid.**—Abbott Laboratories, Parke, Davis and Company, and Davis and Geck, Inc., have awarded grants to the University of Illinois in support of projects in the College of Medicine. Dr. Mark H. Lepper, Department of Medicine, has received a grant in the amount of \$4,032 in support of a six-month study of a repository penicillin which is a product of Abbott Laboratories, North Chicago. Dr. S. B. Binkley, Department of Biological Chemistry, has received a \$3,600 grant from Parke, Davis and Company, Detroit, Mich., for an investigation of blood dyscrasias. Dr. Warren H. Cole and Dr. H. P. Jenkins, Department of Surgery, have received \$500 from Davis and Geck, Brooklyn, N. Y., representing continued support of a visual education grant established in 1950. The grant is used to defray the cost of moving pictures used in visual education.

**Gold Medal Goes to Dr. Orndoff.**—The gold medal of the American College of Radiology was presented to Dr. Benjamin Orndoff, radiologist at Grant Hospital. The award, which has been given only ten times during the college's thirty year history, was presented at a banquet in the Drake Hotel in February. A graduate of Loyola University Medical School, now known as Stritch University Medical School, in 1908, Dr. Orndoff is also a member of the staff at Grant, a position he has held since 1928.

**New Type Control Room Feature of Proposed Addition at Passavant.**—Passavant Memorial Hospital is contemplating installation of a temperature and atmospheric pressure control room for treating patients in the \$3,000,000 addition it hopes to

start building this fall, according to the Chicago Tribune, January 25. Patients suffering from certain forms of heart and blood vessel disease, as well as other ailments that sometimes respond to a controlled atmospheric environment, will have access to the room for both study purposes and therapy. The chamber will also be piped for oxygen and regulated for humidity under supervision of attending physicians, the newspaper reported. Other innovations planned for the new hospital wing, it was stated, include the possible installation of miniature radio receiving sets that can be placed under a patient's pillow, and a central source for piping oxygen into every room.

## GREENE

**Society News.**—Dr. Joseph J. Mira, Alton, addressed the Greene County Medical Society, March 16, at Mabel's Tea Room, Carrollton, on "Fractures of the Lower Extremities. Dr. Mira is a member of St. Joseph's and Alton Memorial hospitals in Alton, and a specialist certified by the American Board of Orthopaedic Surgery.

## KNOX

**Local Newspaper Co-Sponsor Medical Forum.**—The Knox County Medical Society and the Galesburg Register Mail are cooperating in two public medical forums this spring, the subjects to be announced later. It is planned to have a panel of four or five local physicians to answer questions sent in to the Register Mail on a given subject. The society also recently voted to furnish funds for the rental of thirteen radio programs on medical subjects of interest to the public. At the February 17 meeting of the county society, Dr. Lawrence Breslow, Chicago, spoke on "The Colicky Baby."

## LAKE

**Executive Secretary for Society Under Consideration.**—The Lake County Medical Society is considering the employment of an executive secretary. The creation of this position would be a new step in the proposed plan to establish permanent quarters for the county medical society.

**Society News.**—D. L. Tabern, Director of the Isotopes Division of Abbott Laboratories, addressed the Lake County Medical Society in Waukegan, February 9, on "How Radioactive Isotopes are Employed in Medicine."

## MACON

**Personal.**—Drs. J. Donald Ferry and Leonard J. Hannapel were recently unanimously elected to membership in the Macon County Medical Society.

**Society News.**—Dr. Lauren V. Ackerman, pathologist at Barnes Hospital, St. Louis, addressed the Macon County Medical Society in the Decatur Club, February 23, on "Soft Tissue Sarcomas, A Clinical Pathological Review of 100 Cases."

## PEORIA

**Physicians and Wives Hold Joint Meeting.**—On February 23 the Peoria Medical Society and its Woman's Auxiliary held a combined meeting in the ballroom of the Pere Marquette Hotel. The program featured a fellowship hour, a buffet dinner, and an address by Dr. Eric Oldberg, professor and head of the department of neurology and neurological surgery, University of Illinois College of Medicine.

## ROCK ISLAND

**Society News.**—Dr. Herbert Trace, Chicago, discussed "Clinical Heart Surgery" before the Rock Island County Medical Society in Moline, February 9. He also covered "Cardiac Arrest."

## SANGAMON

**Society News.**—"Newer Aspects of Peripheral Vascular Disease" was discussed by Dr. Banning G. Lary before the March 4 meeting of the Sangamon County Medical Society in the Elks Club, Springfield. Dr. Lary is instructor in surgery, University of Illinois College of Medicine.

## WINNEBAGO

**Society News.**—Dr. Ovid O. Meyer, professor of medicine, University of Wisconsin School of Medicine, Madison, addressed the Winnebago County Medical Society at the Rockford Country Club, February 9, on "The Diagnosis and Treatment of Hodgkin's Disease and Allied Conditions."

## GENERAL

**Commission for Handicapped Children Reports on Period 1951-1953.**—Nearly three million children in Illinois are covered by the activities of the Commission for Handicapped Children, which was created in 1941 as the official guardian of their interests. The responsibility of the Commission is to study the needs of handicapped children, both physically handicapped and mentally handicapped, in Illinois and to promote an adequate program of services for them. According to a biennial report for the period 1951-1953, the work of the Commission, more specifically, comes under four main headings: Research and fact finding about handicapped children in order to help work out solutions for their problems; Coordination and strengthening of existing services for them; Promotion of new services when they are found needed; education of the public to help create community sensitivity, understanding and acceptance of handicapped youngsters. A major research project undertaken and completed by the Commission during the period covered by this report was a study of the medical, educational, and social situation of approximately 370 youngsters with severe physical disabilities who live in all sections of the state. This project which involved the study of agency records on these children and

interview with the families was undertaken at the request of the Illinois Department Public Welfare. Results of the study indicated, among other things, the need for more coordination, at the community level, of the services of clinics, schools, and social agencies; more counseling services for parents; more educational opportunities for children who have two or more handicaps; more child-centered programs in hospitals and institutions for youngsters with progressive diseases who cannot be cared for in their own homes. Other surveys included a compilation and analysis of the legal and administrative provisions governing the education and training of mentally handicapped children in other states. The objective of this work was to aid in the development of a sound program in Illinois for training mentally retarded children who are now rejected by the public schools. Upon the basis of these studies, the Commission has recommended legislation on their behalf to the 68th General Assembly. Other activities of the Commission have included the distribution of literature, informative informational material to the public, the display of exhibits, and the maintenance of a small specialized library of close to a thousand books, a hundred periodicals and many pamphlets on handicapping conditions. This is available to the general public and to personnel of other agencies as well as to staff members. Copies of this report, which is presented in detail, may be obtained from the Commission for Handicapped Children, 160 North LaSalle Street, Chicago 1.

**Camp for Children With Diabetes.**—A summer camp for diabetic children will be opened for the sixth season under the auspices of The Chicago Diabetes Association, Inc. from July 18, 1954 to August 8, 1954 at Holiday House, Lake Geneva, Wisconsin.

In addition to the regular personnel of the camp, there will be a staff of resident physicians and dietitians, trained in the care of diabetic children, furnished by The Chicago Diabetes Association.

Boys and girls, ages eight through fourteen years are eligible. For further information regarding fees, interested persons should be directed to write or phone the office of The Chicago Diabetes Association. Fees will be set on a sliding scale to meet individual circumstances.

Physicians are requested to notify parents of diabetic children and to supply the names of children who would like to attend camp. Applications may be obtained from, and inquiries should be addressed to: The Chicago Diabetes Association, 5 South Wabash Avenue, Chicago 3, Illinois. Answer 3-1861.

Limited capacity requires prompt application.

**Mississippi Valley Society Awards.**—Highlights of the Eighteenth Annual Meeting of the Mississippi Valley Medical Society at its meeting in

Springfield recently included the following awards: Dr. Robert L. Sanders, Memphis, professor of surgery at the University of Tennessee, for distinguished contributions to clinical medicine; Dr. Cyrus E. Burford, St. Louis, professor of urology, St. Louis University School of Medicine, for unusual and distinguished service to the medical profession; Dr. Arthur H. Keeney, Louisville, director of research, department of ophthalmology, University of Louisville School of Medicine, for his paper in the essay contest on "Grass Roots in the Prevention of Blindness." A fellowship certificate of the Mississippi Valley Medical Society was presented to Dr. Edmund B. Montgomery, Quincy, Illinois. Dr. Montgomery, born in 1858, graduated at Jefferson Medical College in 1878. According to the report announcing the award, Dr. Montgomery, is the dean of medical men in the United States, having been graduated longer from medical college than any other living physician in this country.

**"How to Keep Well" Column Popular.**—Dr. Theodore R. Van Dellen, editor of the Chicago Tribune's "How to Keep Well" column, received a total of 123,221 letters about health problems during 1953, according to a recent report. Most requests were for advice, although some persons offered pet remedies and suggestions, and others complimented the doctor. Those who enclosed self-addressed envelopes for replies received the information they sought on more than 300 subjects. A staff of seven persons spends much of its time answering the mail. Heart trouble, circulation problems, nervous disorders, allergies, dermatology, and intestinal disorders trouble people most, the mail indicates. Quoting Dr. Van Dellen, the report said "We cannot diagnose by mail, of course, but we offer five or six suggestions. Nor are we in competition with doctors. We are trying to help them by telling persons more about diseases than the doctor has the time to do." More than forty other newspapers also publish the Tribune's "How to Keep Well" column which has a total circulation in excess of 11,500,000.

**New Officers for Microscopical Group.**—The State Microscopical Society of Illinois announces the election of the following officers: President, Dr. H. Elishewitz, The Chicago Medical School; 1st Vice President, Mr. Dimitri Sokoleff, Hektoen Institute for Medical Research; 2nd Vice President, Dr. C. Evans Roth, Argonne National Laboratories.

Said to be the second oldest microscopical society in the world, the State Microscopical Society of Illinois was organized in Chicago in 1868 by special State charter. It is also one of the most active scientific societies in the area, holding four meetings a week.

**Lectures on General Practice.**—The Illinois Academy of General Practice resumed its fifth annual postgraduate program with a Spring series of six weekly, two hour lectures held April 13 at Joliet; April 14 at Alton and Chicago; April 15 at Belleville, Moline, Decatur, Danville, Peoria, Herrin, Effingham, Geneva and Rockford, and April 16 at Elmhurst. Subjects for discussion were Pathologic Uterine Bleeding, Diseases of the Chest, Common Orthopedic and Traumatic Conditions, and Common Problems in Gastroenterology.

For further information communicate with the Illinois Academy of General Practice, 14 East Jackson Boulevard, Chicago 4, Illinois.

**Postgraduate Conferences.**—A series of postgraduate conferences have been arranged under the auspices of the Postgraduate Education Committee, of which Dr. George A. Hellmuth is chairman. The Effingham County Medical Society acted as host to the conference in Effingham, February 25, which was held in cooperation with the faculty of the Stritch School of Medicine of Loyola University. Speakers were Drs. Robert F. Dillon, "Digitalis Management"; Peter J. Talso, "Water and Electrolytes"; John B. Hoesley, "Cardiac Irregularities." Dr. George F. O'Brien was moderator of this panel on "The Treatment of Congestive Heart Failure." The other panel on the program was "Carcinoma of the Colon" with Dr. John L. Keeley as moderator. Speakers were Drs. John B. Condon, "Incidence and History"; Anthony J. Guzauskas, "Symptoms and Diagnosis"; and James A. Rooney, "Treatment—Modern Concepts." The evening speaker was Dr. Gertrude M. Engbring, whose subject was "Sarcoidosis." On March 10, in cooperation with the faculty of the University of Illinois College of Medicine, a conference was held at Rockford, with the Winnebago County Medical Society acting as host. The program consisted of three panels: "Liver Function and Liver Function Tests", "Thrombotic Disease and the Anti-Coagulants", and "Tonsillectomy: Medical, Otolaryngologic, Psychiatric Aspects." Speakers who participated in the panels were: Drs. Murray Franklin, Max Samter, Mitchell A. Spellberg, David I. Abramson, Norman B. Roberg, Marc H. Hollender, and Burton Soboroff. The evening speaker was William J. Reilly, Ph.D., New York, New York, who spoke on "Successful Human Relations."—In cooperation with the faculty of the Cook County Graduate School of Medicine, a conference was held March 18 at Carlinville, with the Macoupin County Medical Society as host. The program consisted of two panels: "Gynecological Problems in Daily Practice" and "Jaundice in Liver Disease." Speakers were Drs. Frederick Steigmann, Walter J. Reich, Mitchell J. Nechtow, and Donald D. Kozoll. Dr. Steigmann was the evening speaker on "The Newer Drugs in Gastrointestinal Disease." The staff of Michael Reese

Hospital, Chicago, cooperated in a conference in Sycamore, March 30, with the DeKalb County Medical Society acting as host. Drs. Louis N. Katz, Richard Langendorf and William Brams presented a panel discussion on "Cardiac Therapy Today."

**"Your Doctor Speaks"** over FM Station WFJL.—Since the last issue of the Illinois Medical Journal, the following physicians have appeared in transcribed broadcasts in a series **"Your Doctor Speaks"** over FM Station WFJL:

**Oglesby Paul**, clinical associate professor of medicine, University of Illinois College of Medicine, February 18, on "Surgery on the Heart."

**Donald S. Miller**, professor of orthopedic and traumatic surgery, Chicago Medical School, February 25, on "Pain In and About the Shoulder."

**Herman A. Levy**, clinical assistant professor of medicine, University of Illinois College of Medicine, March 4, on "Food Allergy."

**William E. Adams**, professor of surgery, University of Chicago School of Medicine, March 11, on "Bleeding from the Lungs."

**Lectures Arranged Through the Educational Committee of the Illinois State Medical Society:**

**Howard L. Lange**, Belleville, Ashley School P.T.A., Ashley, March 26, on Problems of Parenthood.

**Harry H. Garner**, Chicago, Pekin Womens' Club, Pekin, April 2, on A Concept of Personality from the Psychiatric Point of View.

**Paul K. Anthony**, Chicago, Nursery Mothers' Club, Chicago, May 4, on Giving Baby a Healthy Start in Life.

**E. William Immermann**, Chicago, Andrew Jackson School P.T.A., Chicago, May 19, on Polio.

**Lawrence Breslow**, Chicago, William P. Gray Elementary School P.T.A., Chicago, May 20, on Summer Health and Safety.

**Lectures Arranged Through the Scientific Service Committee of the Illinois State Medical Society:**

**Lawrence Perlman**, Chicago, Iroquois County Medical Society in Watseka, March 16, on The Management of Coronary Disease.

**Irwin Dritz**, Chicago, Iroquois County Medical Society in Watseka, April 20, on The Patient as an Anesthesia Risk.

**Jules H. Masserman**, Chicago, St. Clair County Medical Society in East St. Louis, May 6, on Scientific Approaches to Psychiatry.

**Chester C. Guy**, Chicago, Henry County Medical Society in Galva, May 12, on Bleeding Peptic Ulcer.

**Gilbert H. Marquardt**, Chicago, Stock Yards Branch of the Chicago Medical Society, May 13, on Newer Developments in the Management of Geriatrics.

**Max Sadove**, Chicago, DeKalb County Medical Society in Sandwich, May 25, on Recent Advances in Anesthesia.

**John P. Coughlin**, Chicago, Lee-Whiteside County Medical Societies in Dixon, May 27, on Problems of Adolescence.

**"All About Baby"** over WBKB, Channel 7.—Since the last issue of the Illinois Medical Journal, the following physicians were scheduled to appear in the telecast **"All About Baby"** which appears daily over Station WBKB:

**Joseph Garthe**, staff pediatrician, St. Anthony's Hospital, Rockford, March 3.

**Kenneth Nolan**, member pediatric staff, DuPage County Memorial Hospital, Elmhurst, March 10.

**Noel G. Shaw**, head of the pediatric staff, St. Francis Hospital, Evanston, March 17.

**Homer S. Parker**, clinical assistant professor in pediatrics, University of Illinois College of Medicine, March 24.

**William J. Ball**, member pediatric staff, St. Joseph Mercy Hospital, Aurora, March 31.

The physicians appearing on **"All About Baby"** are scheduled by the **Educational Committee of the Illinois State Medical Society**. The telecast is produced by the Herbert Laufman Television Productions and is sponsored by Libby Foods and Swift Meats.

## DEATHS

**Victor G. Blum**, Chicago, who graduated at Medizinische Fakultät der Universität, Wien, Germany, in 1900, died March 3, aged 76. He was a member of the Illinois State Medical Society and a member of the staff of Columbus Hospital since 1940.

**Wilhelmina B. Bowles**, Chicago, who graduated at Meharry Medical College, Nashville, in 1922, died December 3, at Miami Beach, aged 54.

**Clement J. DeBere**, Wilmette, who graduated at Rush Medical College in 1922, died March 11, aged 68. He was a member of the Illinois State Medical Society, a past president of the American Proctologic Association, and an attending physician at St. Luke's Hospital.

**George Carl Fisher**, Chicago, who graduated at the College of Physicians and Surgeons of Chicago School of Medicine of the University of Illinois in 1899, died February 3, aged 80. He was a member of the Illinois State Medical Society and had practiced medicine more than fifty years.

**William Francis Gerety**, Danville, who graduated at the College of Physicians and Surgeons of Chicago, School of Medicine of the University of Illinois in 1908, died December 28, aged 70, of coronary thrombosis. He was a member of the Illinois State Medical Society.

**Mark T. Goldstine**, Chicago, who graduated at Rush Medical College in 1900, died in Thomasville, Ga., March 6, aged 75. He was a member of the

Illinois State Medical Society and emeritus associate professor of obstetrics and gynecology at Northwestern University Medical School.

Evaline St. Croix Hash, Chicago, who graduated at the Chicago Homeopathic Medical College in 1902, died February 11, aged 81. She was a member of the Illinois State Medical Society.

James B. Herrick, retired, Chicago, who graduated at Rush Medical College in 1888, died March 7, in Presbyterian Hospital, aged 92. He was a member of the Illinois State Medical Society and emeritus clinical professor of medicine at the University of Illinois College of Medicine.

Alvin Theodore Held, Decatur, who graduated at Harvard Medical School in 1944, died December 8, aged 34. He was a member of the Illinois State Medical Society and on the staffs of Decatur and Macon County Hospital and St. Mary's Hospital.

Richard J. Humel, Riverside, who graduated at Rush Medical College in 1925, died February 25, aged 53. He was a member of the Illinois State Medical Society.

Leo A. Kaplan, Chicago, who graduated at the University of Illinois College of Medicine in 1938, died February 20, aged 42. He was a member of the Illinois State Medical Society, associate clinical professor of neurology and psychiatry at Stritch School of Medicine of Loyola University, and attending neurologist at Cook County Hospital.

Hector G. La Reau, Chicago, who graduated at Marquette University School of Medicine, Milwaukee, in 1913, died March 11, aged 71. He was a member of the Illinois State Medical Society.

Duncan McKenzie, Ottawa, formerly of Chicago, who graduated at Illinois Medical College in 1908,

died March 5, aged 80. He was a member of the Illinois State Medical Society.

Darwin B. Pond, Chicago, who graduated at the Chicago College of Physicians and Surgeons in 1907, died February 9, aged 75. He was a member of the Illinois State Medical Society and head of the orthopedic department at Ravenswood Hospital.

Harold Edward Randell, Chicago, who graduated at the Chicago Medical School in 1937, died January 15, aged 43, of coronary thrombosis. He was a member of the Illinois State Medical Society.

Martin P. Sasko, Chicago, who graduated at the College of Physicians and Surgeons of Chicago, School of Medicine of the University of Illinois, in 1912, died March 6, aged 81. He was a member of the Illinois State Medical Society and a member of the staff at Southtown Hospital for 25 years.

James M. Shearl, Williamsville, who graduated at Barnes Medical College, St. Louis, in 1905, died January 31, aged 76. He was a member of the Illinois State Medical Society.

Roy Adeson Shell, Chicago, who graduated at Meharry Medical College, Nashville, in 1915, died December 13, aged 66, of hypertensive heart disease.

Ruliff L. Truitt, Naperville, who graduated at Hahnemann Medical College and Hospital of Philadelphia in 1898, died March 7, aged 77.

James W. Walker, retired, Chicago, who graduated at Northwestern University Medical School in 1893, died March 11, aged 90.

Arthur F. Wolford, Chicago, who graduated at Bennett Medical College in 1911, died February 21, aged 69. He was a member of the Illinois State Medical Society and a member of the staffs of Woodlawn and Chicago Lying-In Hospitals.

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## RECOMMENDED TECHNIC OF INSULIN ADMINISTRATION

In our experience the technic for subcutaneous insulin therapy in routine use (formation of a skin fold and injection of the material with the syringe held parallel to the skin) is not suitable for insulin administration. The technic which we have successfully employed is as follows:

The skin over the area selected for injection is stretched with the thumb and index finger of one hand and cleansed with a pellet of cotton soaked in alcohol held in the other hand. While the skin is still kept stretched, the syringe is grasped and the needle thrust by quick motion up to the hub at a right angle to the stretched skin. Now the hand used for stretching the skin

takes over the holding of the syringe, while with the other hand a slight traction is exerted on the plunger. If blood appears in the syringe, the latter is withdrawn a few millimeters so that the needle tip remains outside of the blood vessel but still quite deep in the subcutaneous tissue. Insulin is then injected, whereupon, with the hand previously used in stretching of the skin, the cotton pellet saturated with alcohol is placed close to the needle hub. The syringe with the attached needle is removed by rapid motion, and firm pressure is exerted over the injected area. *Maximilian Fabrykant, M.D., and Benjamin I. Ashe, M.D., New York City, Prevention of Local Skin Reactions to Insulin. N. Y. State J. M., December 15, 1953.*



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Elevation Needed?**  
*Here is a Better Approach*

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THE INCREASING number of patients with functional complaints seen in everyday practice no longer constitutes the therapeutic problem of former days. No longer need the physician be concerned with the side actions which heretofore so frequently vitiated the desirable actions of amphetamine in adequate dosage.

**Why court insomnia,  
jitteriness, tremor?**

Rauwidrine solves this problem. It combines in one tablet, 5 mg. of amphetamine sulfate with the cardiac-calming, tranquilizing, mildly sedative action of Rauwiloid® (1 mg.).

The advantages of this combination are apparent. The mood-elevating influence of the amphetamine component is fully retained and augmented by that of Rauwiloid. But the cardiac pounding due to amphetamine is obvi-

ated by the cardiac-calming engendered by Rauwiloid; the jitteriness, irritability, and insomnia so often disturbing when amphetamine alone is used, are held in abeyance by the tranquilizing, mildly sedative influence of Rauwiloid, and without the use of barbiturates.

Since Rauwiloid does not significantly lower the blood pressure in normotensives, it is eminently suited for use in this combination. In hypertensive patients or those with other cardiovascular disease Rauwidrine should be used with caution.

**For obesity, too!**

In weight reduction management Rauwidrine proves advantageous because the appetite-suppressing effect of the contained amphetamine can be maintained for long periods, without fear that amphetamine will become intolerable for the patient.

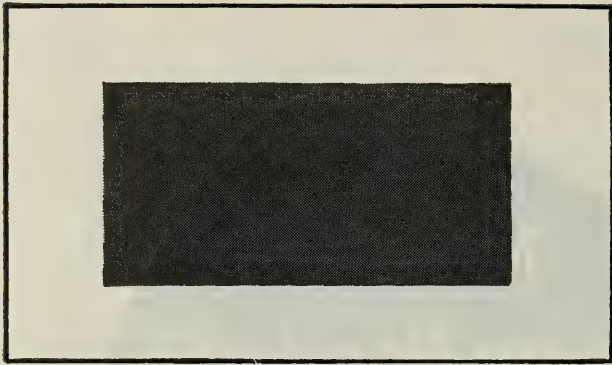
**DOSAGE:** For mood elevation, one to two tablets, each before breakfast and lunch. Dosage should be individualized, and as much as 6 tablets per day (in 3 doses) may be given if needed.

For obesity, one to two tablets 30 to 60 minutes before each meal.

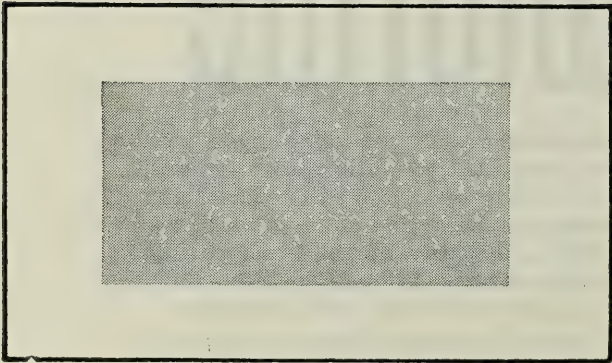
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Ointment BENOQUIN is a new preparation for the treatment of disorders of hyperpigmentation resulting from an increased amount of melanin in the skin. It inhibits melanin formation in human skin. Depigmentation is usually observed after one to four months of continuous treatment . . . generally after the first month.



If erythema or dermatitis develops, discontinue the medication. The medication is not effective in hyperpigmentation resulting from pigments other than melanin.

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BRYAN, OHIO

**TAXING TRAILER RESIDENTS**

Along with other States, Missouri has sanitation problems peculiar to the people living in trailers. Trailer parks have presented a serious sanitation problem during World War II. The number of trailers has increased since the war. People are continuing to live in trailers. Their income frequently is high, and they choose to live in trailers not for economic reasons, but because they like it.

Almost all the sanitation problems common to a small city are found in a trailer park. Water supply, sewage disposal, garbage, and refuse disposal are the major items requiring supervision by the health department. Fortunately, all trailer parks in Jackson County are served by an approved public water supply. Where trailer parks are not served by public sewer systems, the trailer park sewerage systems consist of collection systems, septic tanks, dosing chambers, and open sand filters. In the county, there are 15 trailer parks varying in size from a 10-to 100-unit capacity. A water supply connection and a sewer connection must be provided for every trailer space.

A large percentage of new trailers are equipped with showers, lavatories, kitchen sinks, and flush toilets. These improvements require sanitary sewer and water supply connections for the trailers. The central bathhouse of the typical park is rapidly disappearing. Centralized laundry facilities are, of course, still necessary. Laundry waste is treated with other sanitary sewage and has created no special problems.

Garbage and refuse collection and sewage disposal practices vary from good to bad. Experience indicates that the most satisfactory system is to provide a fly-tight metal container for each trailer unit and to accomplish disposal either by sanitary landfill or by incineration at a remote location. Most of the owner-made incinerators have not been successful. Central refuse containers require almost constant supervision to avoid abuse of the facilities.

The inherent problems of the older trailer parks created by the small unit spaces are being alleviated by the need for accommodating the new, larger trailers and the development of trailer park standards by the National Association of Trailer Coach Manufacturers.

Real estate interests and school authorities in

*(Continued on page 52)*

# cancer man's cruelest enemy strike back

THE FIGHT against cancer is being waged ceaselessly in the research laboratory, in the hospital, the doctor's office. With new methods of diagnosis and treatment, medical science now has weapons to combat man's cruelest enemy more effectively than ever.

THESE LIFESAVING ADVANCES have been made possible by the generous contributions of your fellow Americans. To them the Sword of Hope, symbol of the American Cancer Society's attack through research, education and service to patients, gives assurance of continuing progress today . . . of greater gains tomorrow.

JOIN WITH THEM in striking back with a gift to the American Cancer Society.

## American Cancer Society

GENTLEMEN:

- ☐ Please send me free information on cancer.
- ☐ Enclosed is my contribution of \$ . . . . . to the cancer crusade.

Name . . . . .

Address . . . . .

City . . . . . State . . . . .

Simply address the envelope:

CANCER c/o Postmaster, Name of Your Town

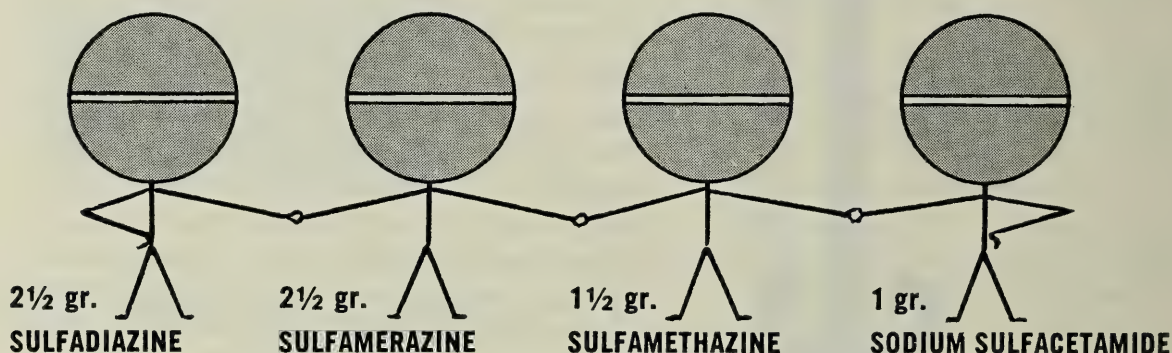
## TRAILERS (Continued)

the county strongly object to trailer parks. School authorities object because little, if any, tax revenue is obtained from the trailer occupants. A small school, or even a fairly large one, with a park of 150 trailers within its district, faces the problem of educating 50 to 75 extra pupils without adequate funds for additional space, equipment, or teaching personnel. The school board and others protest to the zoning board against a proposed trailer park and usually find a sympathetic audience.

Probably trailer park residents would not object to being taxed, but there is now no legal way in Missouri to tax them. The trailer coach manufacturers have asked the legislature for legislation to tax trailers for school purposes, but so far the State has adopted none. This problem will continue to exist until some form of legislation permits taxation of trailer occu-

pants. (Note: The 1953 legislature passed legislation permitting counties to tax trailers for school purposes.)

The real estate interests have stated that trailer parks lower real estate values in their vicinity. But we believe that there should be a place in any county or community for well-organized, sanitary trailer parks. Zoning authorities should select areas for such purposes so that there will be better trailer parks, rather than those which have just grown up from 2 or 3 trailers, adding to their original facilities in a hodgepodge fashion. Parks which are built according to a definite plan can be assets to the community. Health departments must face their obvious responsibilities toward the people who live in mobile homes. *Jack K. Smith, M.S.C.E., Jackson County, Missouri, Sanitation Problems in a Suburban Area. Public Health Reports, December, 1953.*



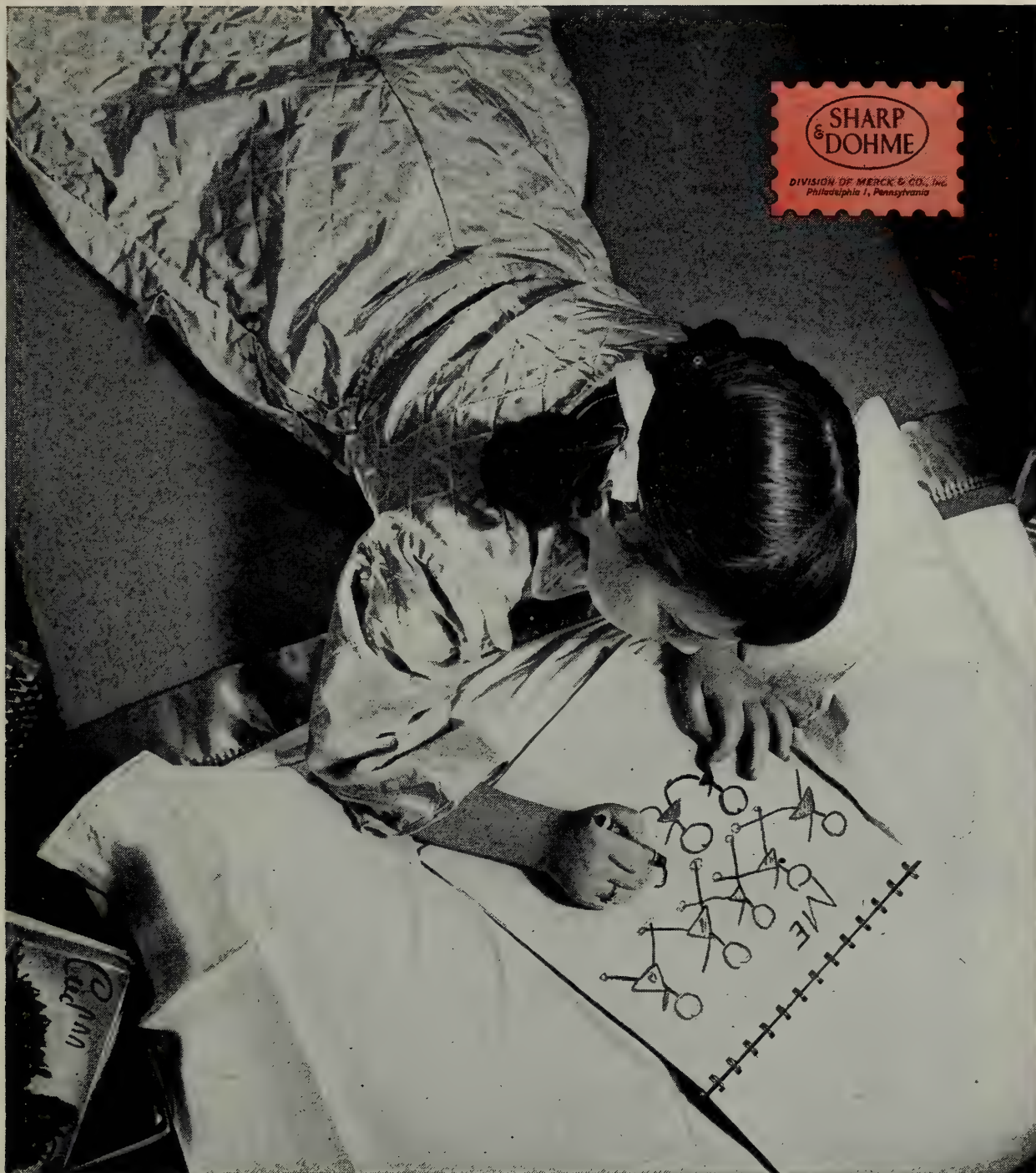
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**Reference:** 1. New York State J. Med. 50:2293, 1950.

## BOOK REVIEWS



**THE ANATOMY AND SURGERY OF HERNIA.** Leo M. Zimmerman, M. D., Professor of Surgery and Co-chairman of the Department of Surgery, Chicago Medical School; Attending Surgeon, Michael Reese, Cook County and Chicago Memorial Hospitals and Barry J. Anson, Ph.D. (Med. Sc.); Professor of Anatomy, Northwestern University Medical School; Member of Attending Staff, Passavant Memorial Hospital. Published by The Williams & Wilkins Company, Baltimore. Copyright 1953; Price \$10.00.

An excellent monograph on hernias arising out of the collaboration of an anatomist and a surgeon.

The introductory chapter presents a rich historic background of management and surgery of hernia from antiquity to the turn of the century. The old plates and drawings illustrating this chapter are quite delightful.

The chapter dealing with the anatomy of the abdominal wall is most detailed and concise. The chapters dealing with specific abdominal hernias, such as an inguinal hernia, are prefaced by a thorough review of the anatomy of the region. This may seem repetitious, but is invaluable. All the anatomical sections of this text are based upon thorough investigations from numerous actual dissections. These dissections have an added value in that they present faithfully,

variations from normal and details how these variations may contribute to herniation.

The book is well printed on gloss paper with satisfactory bibliography and index. The drawing and illustrations are excellent. J. W. P.

**SURGICAL TECHNIQUE and Principles of Operative Surgery.** A. V. Partipilo, M. D., F.A.C.S. Associate Clinical Professor of Surgery, The Stritch School of Medicine of Loyola University. Senior Attending Surgeon, Columbus Hospital. Senior Attending Surgeon, St. Mary's Hospital. Foreward Alton Oschsner, M. D., F.A.C.S., with 548 Figures Containing 998 Illustrations. Copyright 1953. Fifth Edition. Price \$15.00. Lea & Febiger, Philadelphia 6, Pa.

The fact that textbook is now revised into its fifth edition attests to its merit and its popularity not only among students, but men in active surgical practice.

All former chapters have been revised and a new chapter on Fluid Therapy in Surgery by Dr. T. A. Texidor of Northwestern University Medical School has been added.

Whereas the major work has been written single handed by Dr. Partipilo he has included the work of ten outstanding contributors.

A feature not always prominent in most sur-

*(Continued on page 60)*

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*Leukorrhea*

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\*Shaw, H. N.; Henriksen, E.; Kessel, J. F.; and Thompson, C. F.: Clinical and Laboratory Evaluation of "Vagisol" in the Treatment of *Trichomonas Vaginalis Vaginitis*, *Western J. of Surg., Obst. & Gynec.* 60:563 (Nov.) 1952.

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**BOOK REVIEWS (Continued)**

gical texts is the through groundings in basic surgical facts dealing with suture materials, knots and methods of tying which may be found in the introductory chapters.

Surgical technique is detailed for each specific operation clearly and concisely as favored by the contributor to that particular chapter. No attempt is made to review a variety of techniques.

This textbook should make a favorable impression on the reader. J. W. P.

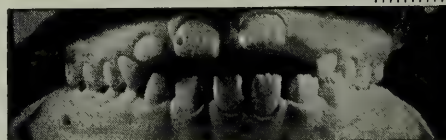
**MANAGING YOUR CORONARY.** Dr. William A. Brams. Illustrations by Hertha Furth. Copyright 1953, Published by J. B. Lippincott Company, Philadelphia and New York. Price \$2.95.

Here is a book made to order for your patients who have suffered coronary thrombosis. It is written in layman's language with faithful adherence to medical facts. It is cheerful and optimistic, but does not under estimate the problem. Dr. Brams explains carefully the working of the heart and what happens to it when one suffers a "heart attack." For purposes of simplification and to avoid confusion, he uses the term "heart attack" as synonymous with coronary thrombosis.

The greatest value to the patient is that portion of the book which deals with what sort of life he can expect to lead following recovery from his heart attack. He answers all the usual questions which arise in the mind of an apprehensive convalescent patient. This will save much anxiety for your timid patient and much time for the busy physician. J.W.P.

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## BOOKS RECEIVED

The following books have been received for reviewing, and are herewith acknowledged. This listing should be considered as a sufficient return for the courtesy of the sender. Books that appear to be of unusual interest will be reviewed as space permits each month. Readers desiring additional information relative to books listed, may write the Editor who will gladly furnish same promptly.

**THORACIC SURGERY:** Richard H. Sweet, M.D., Associate Clinical Professor of Surgery, Harvard University Medical School. Illustrations by: Jorge Rodriguez Arroyo, M.D., formerly Assistant in Surgical Therapeutics, University of Mexico Medical School. New, Second Edition. 381 pages with 159 illustrations. Philadelphia and London: W. B. Saunders Company, 1954. \$10.00.

**THE THYROID** — A Physiological, Pathological, Clinical and Surgical Study. By T. Levitt, M.A., F.R.C.S. (Eng.), F.R.C.S. (Ed.), F.R.C.S.I. Hunterian Professor of the Royal College of Surgeons of England; Lecturer in Surgery to the Fellowship of Postgraduate Medicine at the New End Hospital, Hampstead, London; sometime Surgeon, Paddington Hospital, London; First Surgical Assistant, Throid Clinic, New End Hospital, London; Demonstrator in Anatomy, Middlesex Hospital, University of London. E. & S. Livingstone, LTD, Edinburgh and London, \$20.00.

**CHILDREN FOR THE CHILDLESS** — A Concise Explanation of the Medical, Scientific, and Legal Facts About Conception, Fertility, Sterility, Heredity, and Adoption. Edited by Morris Fishbein, M.D. Chapters by Sidonie Matsner Gruenberg, Morris Fishbein, M.D., Edward Weiss, M.D., I. C. Rubin, M.D., Nicholson J. Eastman, M.D., J. P. Greenhill, M.D., Fred B. Kyger, M.D., and Richard L. Jenkins, M.D., and Benjamin C. Gruenberg, Ph.D. Doubleday & Company, Inc., Garden City, New York. \$2.95.

**THE JEALOUS CHILD.** By Edward Podolsky, M.D., Department of Psychiatry, Kings County Hospital, Brooklyn, New York. Philosophical Library, New York. \$3.75.

(Continued on page 64)

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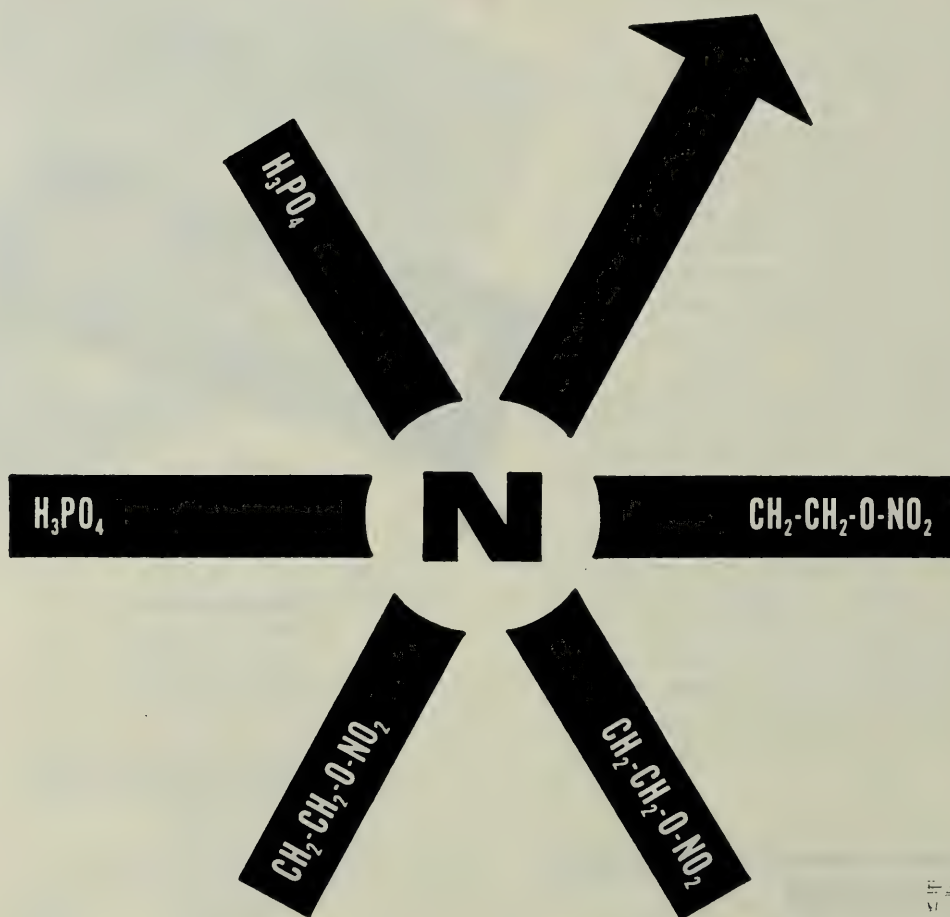
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#### REFERENCES:

1. Palmer, J.H., and Ramsey, C.G.: *Canadian M.A.J.*, 65:16, July, 1951; P. Dailheu-Geoffroy: *La Clinique*, 46:27, May 1951.
2. Melville, K.I., and Lu, F.C.: *Canadian M.A.J.*, 65:11, 1951.
3. Pfeiffer, H.: *Klin. Wochenschr.*, 28:304, 1950.

## POST-GRADUATE COURSE IN SURGERY

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## BOOKS RECEIVED (Continued)

**YOU AND YOUR HEALTH.** By Edwin P. Jordan, M.D., Executive Director, American Association, of Medical Clinics. G. P. Putnam's Sons, New York, \$3.95.

**PRACTICAL ELECTROCARDIOGRAPHY.** By Henry J. L. Marriott, M.D., Associate Professor of Medicine, University of Maryland; Assistant Cardiologist, Mercy Hospital, Baltimore. Illustrated by Marcie Ethridge Perry. The Williams & Wilkins Company, Baltimore. \$5.00.

**PSYCHOSOMATIC CASE BOOK.** By Roy R. Grinker, M.D., Director, Institute for Psychosomatic and Psychiatric Research and Training of the Michael Reese Hospital, Clinical Professor of Psychiatry, University of Illinois, College of Medicine, and Fred P. Robbins, M.D., Associate Psychiatrist, Michael Reese Hospital. Staff Member, The Chicago Institute for Psychoanalysis. The Blakiston Company, Inc., New York, Toronto. \$6.50.

**UNDERSTANDING THE JAPANESE MIND.** By James Clark Moloney, M.D., Philosophical Library, New York. \$3.50.

**THE ALLERGIC CHILD — A Help & Guide to Parents.** By Harry Swartz, M.D., Coward-McCann, Inc., New York. \$3.95.

**1954 MEDICAL PROGRESS — A Review of Medical Advances During 1953.** Morris Fishbein, M.D., Editor. The Blakiston Company Inc., New York, Toronto. \$5.00.

**THE HEPATIC CIRCULATION AND PORTAL HYPERTENSION:** By Charles G. Child, III, M.D., Professor of Surgery, Tufts College Medical School; Chairman, Department of Surgery, New England Center Hospital. From the Department of Surgery and the Laboratory of Surgical Research of the New York Hospital — Cornell Medical Center. 444 pages with 132 figures. Philadelphia and London; W. B. Saunders Company, 1954. \$12.00.

**RECONSTRUCTIVE SURGERY OF THE EYELIDS.** By Wendell L. Hughes, M.D., F.A.C.S., Hempstead, New York. 268 illustrations. Second edition. The C. V. Mosby Company, St. Louis, \$8.50.

Although much progress has been made, multiple screening is still in an evolutionary stage. Screening and follow-up programs for syphilis and tuberculosis have been highly developed, but this is not true of screening for other diseases or for groups of diseases. Much remains to be learned through evaluation of multiple screening, in terms of accomplishments and costs of procedures to be followed at various stages from the original screening through the entire follow up. Arnold B. Kurlander, M.D., and Benjamin E. Carroll, M.A., Pub. Health Reports, Nov., 1953.

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## THE PATHOLOGY OF CARCINOMA OF THE LUNG

Edwin F. Hirsch, M.D.

Chicago

Pathologists during the past twenty-five years have observed a marked increase of carcinoma of the lung in biopsies, in surgical tissues, and in necropsies. The presence of these tumors of the lungs often is disclosed in roentgenograms. Many patients with symptoms of a bronchial lesion have bronchoscopic examinations. Small pieces of tissues and bronchial secretions are obtained thereby for diagnostic purposes. Carcinoma of the lung may occur at any age, but it is more frequent after 40 years, and in men more often than in women. Cough, symptoms of a lung infection, pain in the chest, hemoptysis, purulent sputum are the usual complaints of these patients. Many carcinomas are near the hilum of a lung, but they occur at any level to the periphery. The effects produced by the growth of these carcinomas are local or remote, the latter due usually to metastases. The tumors range in size. Bulky growths cast large shadows in roentgen films, the small do not. Hilar carcinomas can spread into the mediasti-

num, compress the pulmonary blood vessels, encroach upon the heart and even erode the esophagus.

The invasion of the lymph channels and of the pulmonary blood vessels in the lungs by carcinoma enables a widespread dissemination of the disease into many parts of the body. Metastases appear in mediastinal and cervical lymph nodes. Secondary growths in the pleura, the brain, the bones, the kidneys, the suprarenal glands, the skin, the liver, the thyroid, the myocardium and other places cause symptoms which may be dominant in the illness of the patient, while those due to the primary growth in the lungs are insignificant. The bizarre character of the clinical symptoms in these patients presents an enigma. Should a metastatic lesion, approachable by biopsy procedures, be discovered and examined during life, a clue to the nature of the disease in the patient is obtained. Otherwise, the bronchogenic carcinoma is revealed only when a careful necropsy is performed later. The histologic structure of bronchogenic carcinomas ranges from those composed of small cells to those

*(Continued on page 70)*



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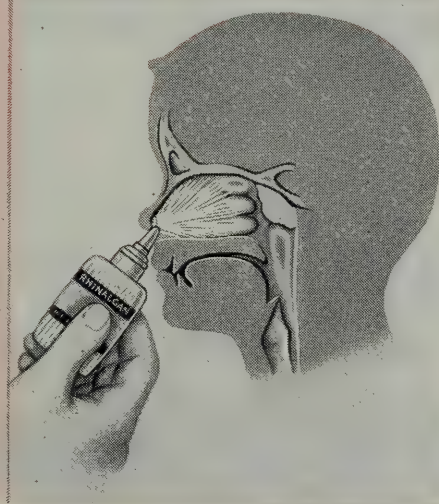
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#### Reference to RHINALGAN:

1. Van Alyea, O. E., and Donnelly, W. A.: E.E.N.&T. Monthly, 31, Nov. 1952.
2. Fox, S. L.: AMA Arch. Otolaryn., 53, 607-609, 1951.
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4. Lett, J. E., (Lt. Col. MC-USAF) Research Report, Dept. Otolaryn., USAF School Aviat. Med., 1952.
5. Hamilton, W. F., and Turnbull, F. M.: J. Amer. Pharm. Ass'n., 7, 378-382, 1950.
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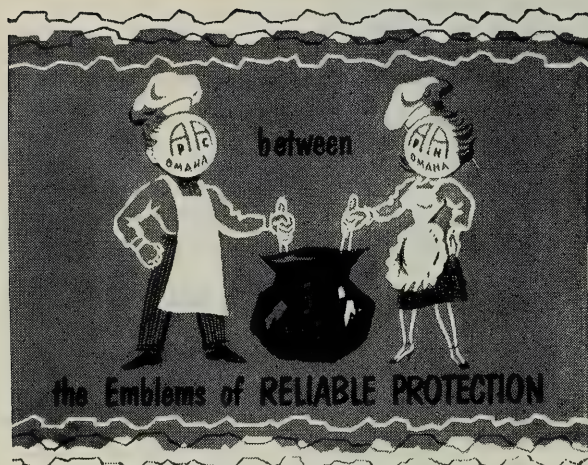
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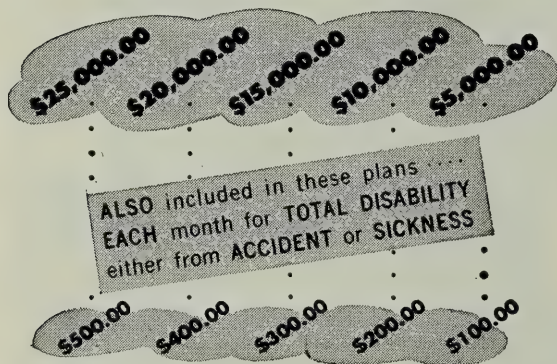
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## **PATHOLOGY (Continued)**

with cells like squamous epithelium. Others are papillary or glandular, and occasionally mucinous, that is, carcinoma tissues composed of "signet cells".

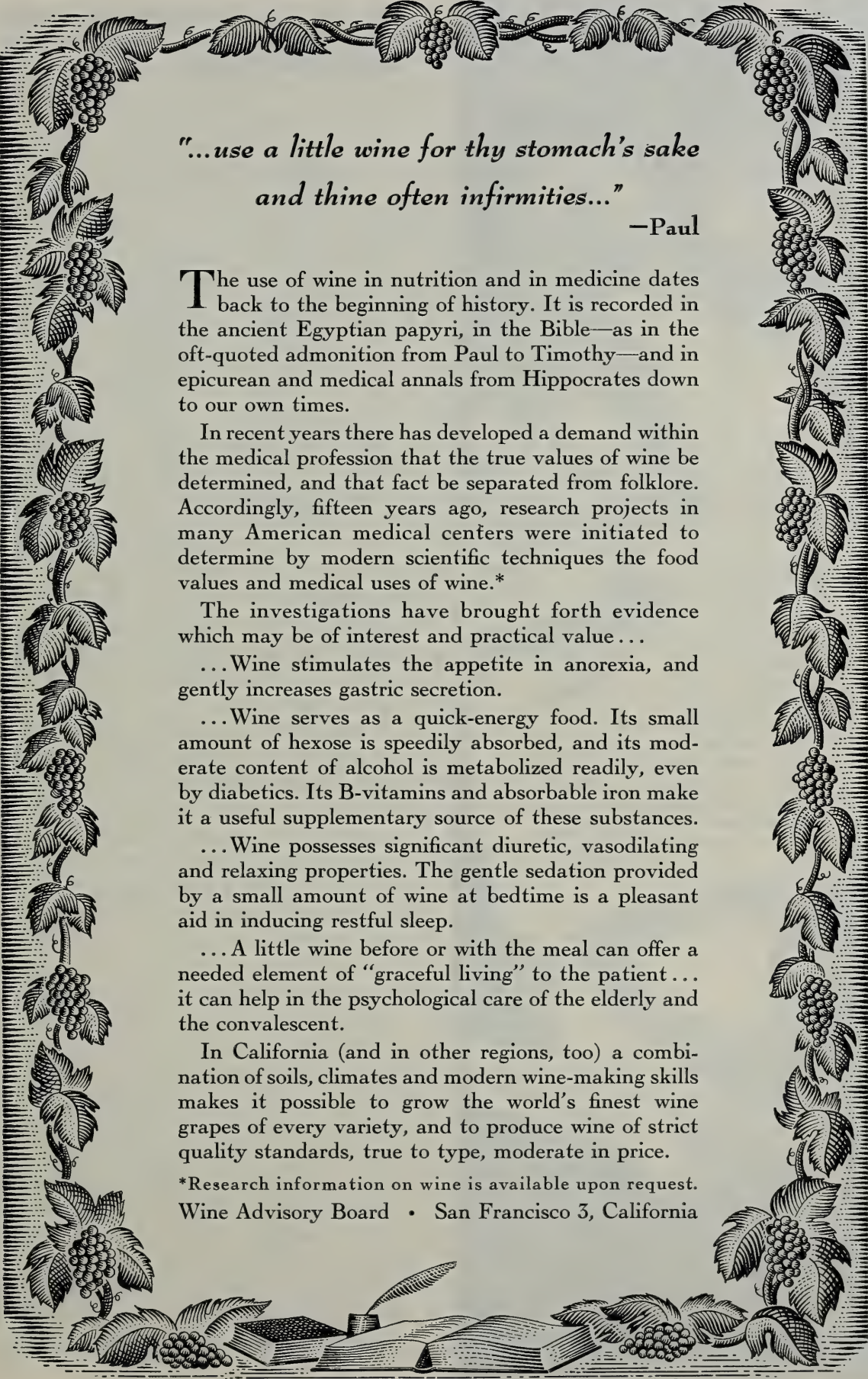
Biopsy tissues containing carcinoma are important in establishing a diagnosis. Many of the tumors near the hilum can be reached with instruments through a bronchoscope. Fragments of tumor tissues or cell masses for diagnostic purposes are sometimes obtained by bronchial aspiration. Other biopsy tissues are obtained by direct approach.

Evidence of a bronchogenic carcinoma of the lung may come from demonstrating a metastatic lesion with the cell structure mentioned in a metastasis. The actual presence of such a primary focus in the lung can be postulated only to the extent that the cell characteristics of the metastatic lesion permit. The small-celled carcinomas of the lungs have highly specific morphologic characteristics. Sections of pleural exudates can give valuable information in the clinical diagnosis of bronchogenic carcinoma.

Many specific examples of unusual symptoms observed in patients with bronchogenic carcinoma, emphasize that this tumor or its metastases can produce a great variety of clinical symptoms besides those commonly mentioned.

## **TOXOPLASMOSIS**

Treatment (of toxoplasmosis) at present can be suggested only on the basis of animal experiments. The ordinary antibiotics appear to be useless. Sulfadiazine arrests acute experimental infections and prolongs the life of the animals while better treatment is continued, but relapse usually follows as soon as this is stopped. Better results have been reported from the use of the antimalarial drug, daraprim, a 2:4-diamino pyrimidine, which cured permanently up to 25 or 35 per cent of the mice. Eyles found that sulfadiazine and daraprim exerted a synergistic action, in that the minimum effective dose of each was much reduced and up to 60 per cent of the animals were permanently cured. Their effectiveness in eliminating chronic infection has not been demonstrated. It seems unlikely that either drug will notably affect the organisms in the pseudocysts. A safe effective dose for man has not yet been worked out. *Editorial, Human Toxoplasmosis. Ann. Int. Med. Nov. 1953.*



*"...use a little wine for thy stomach's sake  
and thine often infirmities..."*

—Paul

The use of wine in nutrition and in medicine dates back to the beginning of history. It is recorded in the ancient Egyptian papyri, in the Bible—as in the oft-quoted admonition from Paul to Timothy—and in epicurean and medical annals from Hippocrates down to our own times.

In recent years there has developed a demand within the medical profession that the true values of wine be determined, and that fact be separated from folklore. Accordingly, fifteen years ago, research projects in many American medical centers were initiated to determine by modern scientific techniques the food values and medical uses of wine.\*

The investigations have brought forth evidence which may be of interest and practical value...

...Wine stimulates the appetite in anorexia, and gently increases gastric secretion.

...Wine serves as a quick-energy food. Its small amount of hexose is speedily absorbed, and its moderate content of alcohol is metabolized readily, even by diabetics. Its B-vitamins and absorbable iron make it a useful supplementary source of these substances.

...Wine possesses significant diuretic, vasodilating and relaxing properties. The gentle sedation provided by a small amount of wine at bedtime is a pleasant aid in inducing restful sleep.

...A little wine before or with the meal can offer a needed element of "graceful living" to the patient... it can help in the psychological care of the elderly and the convalescent.

In California (and in other regions, too) a combination of soils, climates and modern wine-making skills makes it possible to grow the world's finest wine grapes of every variety, and to produce wine of strict quality standards, true to type, moderate in price.

\*Research information on wine is available upon request.  
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## THE AGE RELATIONSHIP OF CASES OF PULMONARY TUBERCULOSIS AND THEIR ASSOCIATES

By Arthur B. Robins, M.D., *American Journal of Public Health*, June, 1953.

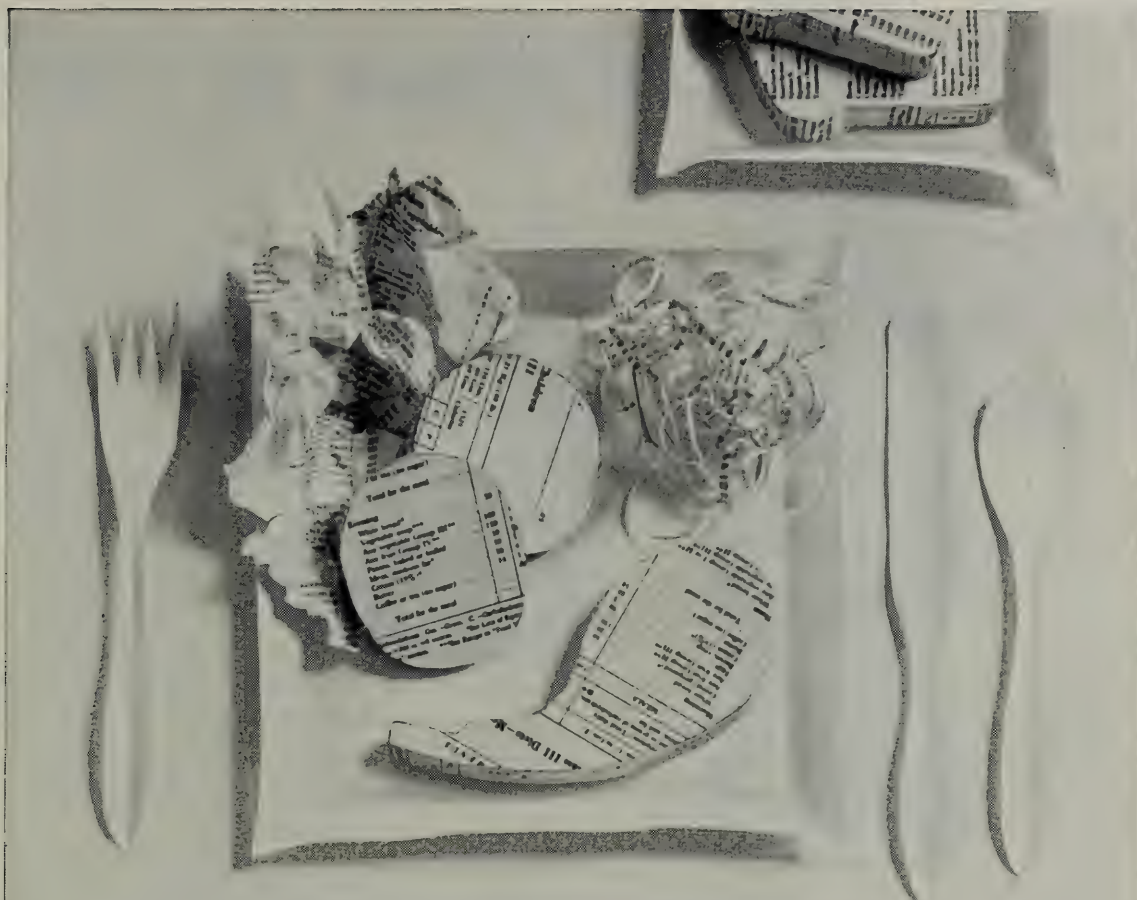
The most significant recent trend in the epidemiology of tuberculosis is the degree to which the disease is affecting older people, particularly older men. In 1932, 37 per cent of the deaths from pulmonary tuberculosis in New York City occurred in individuals 45 years and over, and 78 per cent of these deaths were among males. At this time only one-quarter of the newly reported cases of pulmonary tuberculosis developed in this age group, and less than one-fifth among older men.

By 1950, less than 20 years later, the proportion of new cases and deaths from pulmonary tuberculosis occurring in persons 45 and over had doubled. More than 65 per cent of the residents of New York City who died of the disease were 45 and over, and men were responsible for 85 per cent of these deaths. Similarly, almost half of the newly reported cases of pulmonary tuberculosis were now found in people 45 and over, and males in this age group contributed 36 per cent of all new cases.

During this same period a sharp decline in the percentage of children reacting to the tuberculin test was noted. The mortality from all forms of tuberculosis in persons under 10 years of age reached an all-time low. A major factor in these reductions was undoubtedly the decrease in tuberculous infection in the community. This decline can be attributed to the presence of fewer communicable cases of the disease, their more effective isolation, and the increased resistance of exposed individuals resulting from their improved standard of living. In addition, another possible explanation of the much sharper decline in tuberculous infection in childhood presents itself. Could fewer children under 10 have been exposed to household infection during recent years because source cases were older and less likely to have younger children living with them?

To test this hypothesis a study of the households of persons with pulmonary tuberculosis first reported in 1950 was undertaken. Only male index cases were included, since it had been demonstrated that the postponement of the age of peak morbidity and mortality from tuber-

(Continued on page 74)



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## **TUBERCULOSIS (Continued)**

culosis was due primarily to the shift toward the older ages in males. A sample of 778 cases was selected at random from the total of 3,467 men more than 25 years old with pulmonary tuberculosis reported for the first time in 1950. The results may be summarized as follows:

1. Study of representative samples of the households of males 25-44 years of age with pulmonary tuberculosis and those 45 and over, reported in New York City in 1950, reveals characteristic variations in their composition.

2. Older individuals with tuberculosis have fewer household members, and their associates are less frequently under 10 years of age, than younger persons with the disease.

3. These differences may have been a major factor in the relatively greater reduction in tuberculous infection, morbidity, and mortality in childhood over the past 20 years.

4. This factor may contribute materially to the rapid rise in the incidence of tuberculosis which occurs in adolescents and young adults.

The observations show some of the effects produced by the shift in tuberculosis morbidity to

the older ages, particularly in men. As previously mentioned, the proportion of new cases reported in males 45 and over has doubled in less than a generation. Not only is pulmonary tuberculosis more frequent in older men, but it is also in a more advanced stage at the time of discovery. Fifty-six per cent of males 45 and over, compared with less than 40 per cent of men 25-44, newly reported as tuberculous in New York City in 1950, had far advanced disease at the time of report. The difference in the number of associates exposed to massive infection in the households of the two groups was even greater.

As a result of these differences the risk of tuberculous infection in certain segments of the population has been materially altered. The danger of contagion has become greater for the associates of older patients, and less for the associates of younger patients of tuberculosis. This statement applies particularly to the immediate households of tuberculous individuals. Study of such households show that they vary in several important respects. Parents and siblings make up a larger proportion of the associates of male

*(Continued on page 76)*

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## TUBERCULOSIS (Continued)

patients, 25-44 years of age, than of the associates of older men with the disease. Descendants of all ages are somewhat more frequently present in the homes of patients 45 and over. On the other hand, it consideration is given to the size of the household, a different picture is presented. Two-thirds of the older men with tuberculosis are without household associates, or list only one, presumably a spouse. By contrast, 53 per cent of the younger patients have no, or only one, household contact. The sample studied contains an average of 1.9 household associates for each male patient with tuberculosis under 45, and 1.4 household associates for each 45 and over at time of report.

The aspect of the subject of greatest interest is the age of the associates in relationship to the age of the index case. Comparison of the households of the two groups of patients indicates a marked concentration of young children in the homes of younger men with tuberculosis. When marital partners are excluded, more than 37 per

cent of the associates of the younger group are under 10 years of age, which is more than twice the proportion of children found among the associates of males 45 and over. Individuals between 10 and 34 form a significantly greater part of the households of older patients, primarily as a result of the large number of 15- to 24-year olds included among them. The same trends, with minor variations, characterize the age distribution of male and female household members considered separately.

The implications of these findings in the epidemiology of tuberculosis are far-reaching. There is general agreement that the level of tuberculous infection in the community has become lower during the past 20 years as a result of the reduction in the number of communicable cases. A more rapid decrease in the extent of the tuberculosis problem in children has also been noted, but no adequate explanation for it has been advanced. This study would suggest that the relationship between the age of household associates

(Continued on page 78)

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1. Rev. Gastroenterology 20:744 (Oct.) 1953; abstract in J. A. M. A., 153:1580 (Dec. 26) 1953.

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(Continued on page 80)

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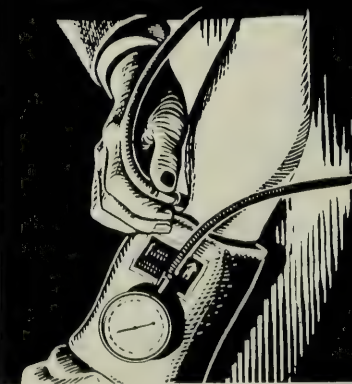
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There is a very real need for a strong educational program to disabuse the general public, health administrations, and legislators of the false notion that mortality reductions and "wonder drugs" spell the end of tuberculosis. *Hastings H. Walker, M.D., Am. Rev. Tuberc., Dec., 1953.*

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- Morgan, W.G.: Tice Practice of Medicine, W.F. Prior Co., Vol. 7, 1944, p.670.
- U.S. Dispensatory, 24th ed.: 807(1947).
- Lichtman, S.S.: Diseases of the Liver, Gallbladder and Bile Ducts, ed. 2, Phila., Lea & Febiger, 1949, p.963.

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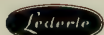
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May, 1954

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## Neonatal Death — Its Prevention A Symposium

### Intra-uterine Accidents and Complications

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### Intra-uterine Accidents and Complications

**Frederick H. Falls, M.D.**

We feel that the obstetrician has the responsibility for attempting to prevent certain pre- and postnatal deaths, because of conditions which develop during early pregnancy, after the period of viability, during labor and immediately following its conclusion. Some of these conditions are preventable and some are quite unpreventable. I thought that possibly the best way to put the subject before you was to show a series of pictures which indicate the problems of the obstetrician which have to be solved before we can completely eliminate these neonatal and intra-uterine deaths. I doubt if the problem will ever be completely solved. A meeting such as this of pediatricians, obstetricians, pathologists and anesthesiologists, should contribute to our approaching the goal which we are all seeking.

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*Cephalopelvic Disproportion.*—This slide dramatizes the situation in which the obstetrician finds himself when there is a marked disproportion between the size of the fetal head and the pelvis. It is quite obvious that that head could not come through that pelvis without serious danger to the baby, whether it delivers spontaneously or by forceps. Therefore, the obstetrician has to decide whether that danger is greater to the baby than the danger of cesarean section. That judgment can only be derived from experience. We call in the x-ray man to help us with more exact measurements, but he cannot tell us about the anoxemia which may result, due to strong pains necessary to pass the head through these diameters. So it devolves upon the obstetrician to get all the help he can; but he must be the final judge as to whether the head can safely mold and be delivered through this pelvis.

*Premature Labor.*—There are patients who, when they reach a certain period of their pregnancy, for unknown reasons go into labor and deliver prematurely. This may happen at the fifth or sixth month, or closer to term. These premature deliveries may or may not be due to an obvious cause. It behooves the obstetrician or general practitioner to search for the causes that can be determined, and eliminate them in subsequent pregnancies. If the accident happens repeatedly after viability of the baby, it is better to deliver the baby by cesarean section before such critical time.

*Breech Presentation.*—In this slide we show the hazard that occurs in breech presentation. The breech does not fill the inlet of the pelvis as well as does the head. One must anticipate the possibility of prolapse of the cord as shown here, with a bulging amnion and an incompletely dilated cervix. When the membranes rupture and the cord prolapses and is compressed, only a period of a few minutes may determine whether or not the baby will survive. The obstetrician has to be ready for such eventualities. He has to have oxygen for resuscitation of the baby. He must have instruments ready to dilate and incise the cervix, and various accessories to meet these complications. If these are ready the mortality of these infants is greatly reduced and the necessity for special methods of resuscitation is greatly reduced.

*Placenta Previa.*—This slide shows the situation in placenta previa, and how one can determine whether or not the baby will be in jeopardy. With a marginal placenta previa in which there is only a slight separation it is important not to run the risk to the mother and baby of a cesarean section, but by rupturing the membranes permit the cervix to expand gradually and allow the head to come down and deliver spontaneously. That decision must be a tentative one. If you rupture the membranes and the head comes down, and the heart tones accelerate dangerously or stop, you know that the head is compressing the cord and the baby is in jeopardy. Therefore, the best thing is to hold the head off the cord until you can get the patient to the operating room and deliver the baby.

Two problems are present in this next slide; you have an immature baby. Central placenta previa almost always becomes manifest about the

seventh month. If you deliver the baby it will die of prematurity, possibly. If you do not deliver it, it may die because the mother may die of hemorrhage. You must decide whether you can stop the hemorrhage temporarily, how much blood the mother has lost already, and how much blood she can afford to lose, and what are the possibilities of replacement. Also you must determine whether you can hold the baby over until you can get more maturity. This can only be risked when you have proper facilities to house the mother, so that if another hemorrhage does occur you can rescue her even if the baby is unable to survive because of prematurity. In these cases we have tried to prevent further separation of the placenta by quieting the Braxton Hicks' contractions by the use of lutein solution, 3 c.c. three times a day, in addition to bed rest.

This slide shows the danger of intraovular introduction of a Voorhees' bag to stop the hemorrhage from placenta previa. It may stop the hemorrhage very well, but if the bag is rather large — and it must be large in order to produce the amount of dilatation necessary to deliver the baby — the bag may compress the cord and kill the baby. A calculate risk must be run. This must be understood when any form of delivery from below is undertaken in placenta previa.

This slide shows that the same thing will happen if you do the more conservative Braxton Hicks' version. The buttocks and the back of the baby also may compress the cord and kill the infant.

This slide shows the relationship of placenta previa to an encephalic monster. For some reason there is a relatively high percentage of placenta previa in such pregnancies. In patients with placenta previa one should always take an x-ray picture to be sure you are not dealing with a monster as well, because the obvious procedure here is to disregard the baby and deliver through the lower segment even if you are quite sure you will cut off the circulation of the cord before delivery is complete.

This slide shows the situation when there is complete premature detachment of the placenta. Here the baby has died, as most of them do within a few minutes when this accident occurs, and it is extremely dangerous to deliver from below because even after removing the dead baby, there

will be atony of the uterine muscles based on overdistention by intrauterine blood, and even though you have to do a cesarean section on a dead baby, it is best to do so, remove the dead baby and then, if necessary, remove the uterus in order to save the mother from uncontrollable postpartum hemorrhage.

This slide shows a premature detachment which occurs when the baby is near term, when the woman is in labor and the cervix is incompletely dilated. The simplest thing to do under such circumstances is to complete the dilatation of the cervix manually, do a version and extract the baby, and then remove the placenta manually if necessary. Again, the amount of bleeding and the severity of contractions may produce anoxemia of the baby which will have to be combated as soon as the baby is delivered. Oxygen, tracheal catheters and stimulants should be assembled during the time you are getting ready to deliver the baby. The avoidance of procrastination in making the arrangements to combat shock and asphyxia is what I wish to stress.

Sometimes very suddenly the placenta comes off and is delivered ahead of the baby; what is called prolapse of the placenta. Of course, there is no actual danger to the baby except from asphyxia if not delivered. The placenta must be removed, the cord clamped, and the baby delivered either by version or forceps as seems to be the best procedure, in the individual case.

When the placenta is on the anterior wall, and the cesarean knife has to penetrate through the uterine wall and through the placenta, you never know when that knife is going to cut across the cord or the great placental vessels. As soon as cut they start to bleed furiously while the wound is being enlarged and the baby extracted. So under those circumstances, as soon as we start cutting through the placenta and know that we have this situation to deal with, we lose no time delivering the baby and clamping the cord, thus stopping fetal hemorrhage. Postpartum, we replace any blood that the baby may have lost by transfusion.

*Villamentous Insertion of Cord*—Here is a curious cause of fetal hemorrhage which occurs very rarely but which can occur and not be diagnosed correctly. There can be an insertion of the cord into the membranes over the internal os with the placenta located considerably above the in-

ternal os. If the membranes rupture during early labor, there may be a tear across these vessels. The hemorrhage which occurs is fetal hemorrhage and yet it is interpreted, of course, as being maternal and possibly placenta previa. The baby's heart tones can disappear without anybody suspecting what the real situation is. That should always be taken into consideration and examination made, and if the heart tones begin to show evidence of rapidity or weakness, the fetus should be removed either from above or below depending upon whether the cervix is closed or dilated.

*Threatened Rupture of the Uterus*.—One cannot diagnose the cause of the fetal asphyxia. We have under these circumstances a threatened rupture of the uterus, the head trying to get through and not being able to negotiate the inlet of the pelvis. The uterus then goes into tetanic contractions and as a result the fetus suffers from anoxemia because it cannot get enough oxygen through the contracted uterine wall, and not infrequently from cerebral hemorrhage because of the force of the uterine contractions. When this condition begins to be apparent, particularly with a Bandl's ring and other signs of threatened rupture of the uterus, the contractions should be quieted by deep anesthesia. We believe the baby should be delivered by cesarean section before the uterus ruptured and before hypoxia produces irreversible changes in the cerebral cortex of the baby. If that is not done this (slide) is the only alternative; the baby instead of being born through the natural passages is born into the abdomen, the placenta comes off and the baby dies. That is the only alternative in a ruptured uterus. And because of the severe laceration of the uterine vessels just outside the lower uterine segment, you are very likely to have an uncontrollable maternal hemorrhage before you can get the mother into the operating room and remove the uterus.

*Twins*.—This slide shows the condition of twins in utero. There is always a little more danger to either twin than there would be to a single baby, because there is danger that one of the cords may prolapse after labor starts. A large percentage of twin pregnancies are associated with toxemia, and most of these pregnancies terminate prematurely. Both of these conditions

increase the hazard to the baby. After the first baby has been born, there is danger that the second may have premature detachment of the placenta or prolapse of the cord. Therefore, we set up our defense, even before the complication has occurred so that we will be ready to meet it at the time of delivery.

This slide shows one of the accidents that sometimes occurs, not very often fortunately. One baby will be presenting by breech and the other by the head. The breech will be born down to this point and then there will be a collision and locking of the heads. Under this circumstance even though the first baby is alive, it is practically impossible to unlock the heads, and the only thing to be done is decapitation. The trunk of the first baby is delivered, and then a version and extraction is done on the other baby. The decapitated head of the first baby is then extracted.

Upon birth of the first twin, it is extremely important that immediate examination be made to discover if the cord of the second baby is prolapsed or is likely to prolapse. If so, as soon as the uterus has contracted slightly a leg can be grasped, and a version done, or if the head is in the pelvis the baby can be delivered by forceps extraction.

*Eclamptogenic Toxemia.*—The effect on the toxemic baby is extremely important, and the importance of the fact has been somewhat overshadowed by the fear we have for the life of the mother. We have two patients, and are equally responsible for the lives of each. Both are in jeopardy and our task is to give each its best chance without too seriously endangering the other. The essential pathology is in the placenta

and consists of vascular accidents. As a result of these, if the condition has been going on for some weeks or months, the fetus does not develop as it should because it lacks normal nutrition. The fetus is in jeopardy from malnutrition, from inadequate development, and if the condition is acute it may be associated with severe anoxemia in the fetus. We feel that is one reason why, other things being equal, a cesarean may be the most desirable method of delivery in certain cases of toxemia. It immediately takes the baby out of the uterus where conditions are unusually unfavorable and put it into an environment where we can exert our best efforts in its behalf. All preparations should be made for the care and resuscitation of these babies from toxemic mothers prior to their delivery.

This slide is a diagrammatic representation of the toxemic baby as opposed to the more or less normal baby, and these are the infarcts in the placenta so frequently seen in abundance in these cases that have toxemia. Obviously they suffer from chronic malnutrition, anoxemia, and from the same toxins that damage the mother.

*Fibroid Uterus.*—The baby that is born from a fibroid uterus is in a certain amount of jeopardy because a good deal of the musculature of the uterus is displaced by the fibroid causing a reduction in dynamic strength in the wall of the uterus. As a result malpresentations, anoxemia and prematurity may be expected, all of which may require operative intervention or special care of both in a given case.

Dr. Adams: Frequently as labor progresses the anesthetist joins the obstetrician, and Dr. Searles will speak next on "The Effect of Analgesics and Anesthetics on Fetal Mortality".

# The Effect of Analgesics and Anesthetics on Fetal Mortality

Paul W. Searles, M.D.

This discussion primarily concerns the effect of anesthetic and analgesic drugs on fetal mortality. The respiratory center is the most vulnerable part of the fetus and consequently damage to this mechanism is the most common cause of fetal mortality. Unfortunately the present day analgesic and anesthetic agents all exert a depressant effect upon the respiratory center and consequently any discussion of analgesic or anesthetic drugs for labor involves two questions, (1) the amount of pain relief for the mother and (2) the degree of safety especially for the child. It is indeed paradoxical that, while the relief of pain primarily concerns the mother alone, in reality injury of the child commonly becomes the chief concern.

It should be pointed out that fetuses die during labor or soon after delivery chiefly from respiratory impairment in the form of (1) asphyxia (2) atelectasis (3) congenital pneumonia (4) prematurity.

It is fortunate that it has been possible to study intrauterine fetal respiration in order to compare the effect of various analgesic and anesthetic agents upon the fetus before birth.

Certain effects of drug action, such as prolongation of labor and asphyxia of the fetus are readily magnified by increase in the dosage above the usual therapeutic level. And it should be pointed out that a dosage level which appears to be safe for the mother may result in injury to the child. Cole,<sup>1</sup> 1939, found that sedatives or general anesthesia in any amount definitely increased the incidence of asphyxia in the baby in direct proportion to the amounts given or to the duration of anesthesia, and he also pointed out that deep planes of anesthesia maintained for any length of time placed the child in grave danger. Certainly to hold the mother in deep anesthesia until the obstetrician arrives or scrubs is to be condemned.

In accounting for the variations in the oxygen supply of the fetus following various anesthetic agents, it is evident that not merely the amount of oxygen given, with the anesthetic agent but also the effect of the anesthetic agent itself on the uterine musculature must be borne in mind.

Deep anesthesia may cause temporary paralysis of the uterine muscle thus causing fetal anoxemia.

*For Analgesia.*—Morphine in addition to producing respiratory depression per se, causes delay in emptying of the uterus which is an additional hazard. The use of morphine should be restricted to a single small dose given near the end of the second stage.

From a laboratory point of view, Demerol is an ideal analgesic drug. Clinically, however, it frequently exerts a depressant action equivalent to or greater than morphine. It has an advantage however in that it may be administered closer to the time of delivery without producing excessive depression.

Other narcotic agents have been used but for the most part have proven inadequate either because of poor analgesic properties or of producing severe fetal respiratory depression.

Scopolamine has the power to induce amnesia without the loss of consciousness and apparently has no effect on the activity of the uterus during labor and exerts no significant effect on the child. Scopolamine can be used best as a premedication just prior to the delivery of the child.

Twilight sleep produced by the combination of morphine and scopolamine enjoyed a period of brief popularity but does have the disadvantage of producing restlessness and is contraindicated in cases of primary uterine inertia.

The outstanding effect of the barbiturates is one of sedation and hypnosis. They are hypnotics and have only minimal analgesic properties. The use of excessive dosage, which is common, consequently results in both maternal and fetal respiratory depression.

Paraldehyde may be used when local analgesic or other general anesthetic agents are contraindicated. However the danger of severe depression makes its use questionable.

*For Anesthesia.*—The use of chloroform in obstetrics is more common in this country than is usually thought especially in the rural areas. Its popularity is due to its analgesic effect rather than the anesthetic effect and to the short period of induction. Chloroform is probably the most potent anesthetic administered by inhalation

methods. With chloroform it is the mother who suffers the ill effects and not the child. Its method of destroying life is through respiratory arrest and this occurs with such a narrow margin of safety between respiratory arrest and cardiac failure that one is fearful of the outcome when respiratory arrest has taken place.

of morphine and scopol

There is no injury to the liver of the fetus or to other fetal organs, despite fatal injury of the mother by chloroform. Maternal death with chloroform is usually due to cardiac failure or delayed poisoning, the result of liver necrosis.

I think it should be pointed out that many of the complications encountered with the use of chloroform could be avoided if it were properly administered. Its administration should be accompanied by the use of oxygen with care taken to employ a very slow induction. Such contraindications as dehydration, eclampsia, pernicious vomiting, and cardiac arrhythmias definitely limits the use of chloroform.

There is no doubt that ethyl ether leaves much to be desired in obstetrics. Particularly objectionable are the discomforts it causes the patient and the injurious effects upon metabolism, kidney function and respiratory epithelium. However, it does have a large safety margin for the mother and when relaxation is necessary ether can be depended upon to produce a satisfactory anesthesia.

Divinyl-ether has proved to have many of the desirable effects of chloroform such as rapid and pleasant induction and requires little apparatus for administration. It, too, can produce liver damage following prolonged administration. Therefore, divinyl ether has its greatest field of usefulness for obstetrics when it is employed as an analgesic in short, uncomplicated terminal second stage labor.

Ethyl chloride because of its potency and marked depressant effect upon the body functions is now considered one of the most dangerous anesthetic agents and its use is condemned.

Nitrous oxide has enjoyed the widest popularity among analgesic agents. Dr. J. Clarence Webster of Chicago was one of the first in America to use nitrous oxide and oxygen in obstetrics. Its greatest field of usefulness lies in short obstetric operations such as terminal delivery in uncomplicated cases or as an analgesic

agent when used with labor pains. It should not be used in a high mountain altitude and is contra indicated in profound anemia. A part of its action is due to the production of relative anoxemia in the organism. Eastman<sup>2</sup> has shown that there is definite danger in asphyxia neonatorum with the use of nitrous oxide especially when employed with low oxygen concentrations and Courville has proved that such asphyxia may cause irreparable damage to the higher centers of the brain. The damage may not be sufficient to cause fetal death; the real danger is the production of a retarded mentality, that may show up in later life. Therefore, it is important that the administration of nitrous oxide be accompanied by an adequate concentration of oxygen.

Anesthesia with nitrous oxide and oxygen should always be maintained in a very light plane of surgical anesthesia. Nitrous oxide is incapable of producing deep relaxing anesthesia without producing asphyxia. When relaxation is desired, nitrous oxide must be supplemented with a more potent agent.

Inexperienced medical personnel are frequently allowed to administer a whiff of nitrous oxide. Too often adequate oxygen is not administered and in some instances due to unfamiliarity with anesthetic equipment there is complete failure to turn on the oxygen.

Trichlorethylene has just recently come into use for obstetrics in the United States. The clinical use of trichlorethylene alone is restricted to the production of analgesia and when used in combination with nitrous oxide and oxygen to the production of light surgical anesthesia. It has minimal effects on liver and kidney and the organism as a whole with exception of the cardiovascular system, where it produces vagal over-activity when excessive concentrations are used. When used for analgesia because of its low volatility it is unsuitable for administration by open mask and therefore various types of inhalers are employed. Inhalers should be used for the production of analgesia only and not anesthesia. When anesthesia is desired, trichlorethylene can be easily combined with nitrous oxide for the production of a satisfactory anesthesia for delivery.

Combining trichlorethylene with nitrous oxide and oxygen allows for the maintenance of a

satisfactory plane of anesthesia with more than adequate concentrations of oxygen. It is not necessary to produce cyanosis to obtain a satisfactory anesthesia.

Trichlorethylene has little or no effect on the fetus and may prove, after a more thorough trial, to be one of our most valuable agents for the relief of pain in obstetrics.

The use of ethylene can be compared to that of nitrous oxide as to anesthetic effects but because of its odor and explosive properties it has not proved popular.

From all apparent observations it appears that cyclopropane would be an ideal agent in childbirth, however it does produce a fetal respiratory depression especially with prolonged administration and for this reason it should be employed for short periods at terminal labor and for perineal repair after delivery. Here again, if anoxia is allowed to occur, during the administration of cyclopropane the infant may be difficult to resuscitate.

Continuous caudal anesthesia enjoyed a brief period of popularity due to the work of Hingron and Edwards.<sup>3</sup> This method appeared to produce minimal effects in the fetus but subsequent employment showed that in some instances marked falls in blood pressure endangered the fetus. In addition, only about 40 per cent of deliveries are suitable for caudal technique.

Low saddle block spinal anesthesia has gained a great deal of favor because of its lack of effects in the fetus. However, it should be pointed out that spinal anesthesia is not without complications. Faulty techniques may lead to such complications as cauda equina syndromes etc. To be brief spinal anesthesia should only be used by a skilled anesthetist trained in an exacting technique in order to avoid complications.

There is probably no direct effect of the drug itself but intra-uterine asphyxia results from marked falls in maternal blood pressure. Generally speaking the higher the block, the greater the fall in blood pressure.

From the standpoint of safety from lethal effects on the infant and mother as well, local infiltration stands out pre-eminently as there is practically no fetal mortality from the direct effect of the anesthetic itself.

The problem of asphyxia from aspiration of

foreign material is probably the most important single item both as far as the mother and infant are concerned. It should be pointed out that general anesthesia increases this hazard because disturbances occur in the autonomic system which produce hyperactive throat reflexes and stimulate the vomiting reflex. There is also a loss of muscle tone in the tongue as well as in production of respiratory depression.

In summary, the plea is made for the use of non-asphyxiating mixtures of anesthetics with special care to administer adequate concentration of oxygen both as far as the mother and the infant are concerned in labor. If saddle block or caudal anesthesia are used maternal blood pressure must be checked and maintained at all times to avoid fetal anoxia. When the obstetrical patient is given the same consideration as far as avoiding the full stomachs and the use of proper pre-medication similar to the surgical patient, asphyxia from aspiration of foreign material will be a problem of the past.

It is generally agreed that responsibility for resuscitation for the newborn infant belongs to the anesthesiologist. Because of a limited number of anesthesiologists, this is not always possible, therefore it usually falls to the lot of the obstetrician or pediatrician to carry out this procedure. The fundamental pathological lesion of asphyxia neonatorum clinically is complete atelectasis. The absence of negative intrapleural pressure in the infant who had never breathed is the reason why ordinary methods of artificial respiration (for example Shaefer, etc.) are of no value in asphyxia of the newborn. Stimulant drugs have no place in treatment of asphyxia in the newborn. An intratracheal catheter or a bronchoscope should be passed and gentle suction carried out. Following suction a intermittent, low positive pressure should be applied until respirations of infant have been established after which continuous inhalation of oxygen can be administered until resuscitation is complete.

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Dr. Adams: After the mother with the help of the obstetrician and the anesthetist, has produced an infant, the pediatrician enters the

picture. Dr. Heyworth N. Sanford will discuss "Factors in Infant Care" as they affect the prevention of neonatal deaths.

## Factors in Infant Care

**Heyworth N. Sanford, M.D.**

In the Chicago area, from 1939 to 1949, the infant mortality under one year of age has been reduced about 10 per cent. Unfortunately this reduction has been made mostly in the latter part of the first year, while the mortality of the newborn period has not occurred in the same degree but has been reduced approximately 5 per cent. Newborn mortality has been reduced about 1.5 per cent. If we are further going to reduce this mortality, obviously we must know its cause, and we find this in the excellent studies made by Bundesen, Potter et al, about a year ago.

This slide shows that the greatest cause of infant mortality is abnormal pulmonary ventilation; secondly, injuries at birth; third, malformation; fourth, infections; fifth, blood dyscrasias; sixth, anoxia, and seventh, miscellaneous. You will notice that abnormal pulmonary ventilation causes more than half the total newborn mortality.

I would like to call attention to the fact that the total deaths in the first day of life amounted to 35 per cent; that the total deaths of the next month amounted to 33.7 per cent; and the total deaths of the next 11 months only amounted to 30.5 per cent. In other words, more infants died in the first day of life than died in the entire first month; and more infants died in the first month than in the next 11 months. We are always talking about the most dangerous day in a person's life, and I think this very clearly exemplifies that if you survive the first day of life you have a much better chance of life as the days progress.

Abnormal pulmonary ventilation is usually seen in two conditions, atelectasis and pulmonary hyaline membrane. What do we mean by atelectasis? It simply means that the lung does not completely open up and does not begin to function. There are three places where that may occur — centrally, in the brain or the respiratory center; it can occur peripherally, along the nerves which lead to the lungs; or it can occur in the lung itself. I think we can exclude the

first two because if the respiratory center is not functioning there is not much that can be done except to carry the child along with oxygen until this begins, if ever. The same is true with the nerves leading to it. In atelectasis, or in the lung itself, we seem to find this very frequently associated with pneumomediastinum, pneumothorax, and so forth, showing that there is some attempt in breathing. Atelectasis occurs in two forms; the first form in which there is plugging of a large bronchus and only one or perhaps two lobes may be affected. This can be told by the fact that the child is cyanotic almost at birth. Therefore, we can exclude all extrapulmonary causes of cyanosis such as cerebral hemorrhage, congenital heart, tracheo-esophageal fistula, adrenal hemorrhage or diaphragmatic hernia; we know that it must be in the lung itself. This can be confirmed by x-ray of the chest or fluoroscopy, and we have found it advisable to fluoroscope or x-ray every cyanotic baby after birth to see if this condition exists. If it exists in one or two lobes we use the method of House and Peters, in which a small infant bronchoscope can be inserted and the bronchi drained. All that need be done is to drain the main bronchus, as the others leading to it will drain as well.

Unfortunately, this is not as simple as it sounds because only in a few instances is the atelectasis confined to one lobe; most of the time it is scattered throughout the entire lung, and then the problem is entirely different. In such a case we resort to oxygen or perhaps some form of mechanical stimulation such as a respiratory, which as you know are not entirely satisfactory.

With regard to pulmonary hyaline membrane, we know that it is found in certain instances in premature infants and in full term infants that have had anoxia. Certainly air is necessary for its formation because we never find it in a still-born child. It seems to be a protein material, and whether it is amniotic fluid or from secretions from the larger bronchi we do not know. There does seem to be a certain group of clinical symptoms that we see; those are, first, the baby

is born perfectly normal and we think everything is going well. Then in about two hours there are signs of dyspnea, more labored respiration, and finally cyanosis which deepens, and in many instances the child dies in five or six hours. If they survive this period usually they will go on to recovery.

We formerly had no method for treating these infants except giving oxygen. Lately, there has been a method of giving these children oxygen in a humid atmosphere and adding a detergent to dissolve these mucous secretions. The one we have been using mostly is alevaire, in a glycerine and soda bicarbonate solution. This can be siphoned into the nebulizer in which oxygen is given and it seems to give some degree of improvement. It is not the final answer, because we have had children with massive atelectasis that have died. But it does seem that more children recover following atelectasis than formerly. In any case I think it is well worth further trial.

Another problem we have is the child born by cesarean section. Those children do not have the stimulation of normal birth and never breathe as well as a normal baby. They seem to have an excessive amount of fluids. Potter found that they have edema of the brain and edema in different parts of the body, and we know they are prone to have an excess of fluid in the stomach which they may regurgitate and aspirate. It is our practice that as soon as the baby is born the stomach is washed out, and it is given oxygen for the first 24 or 48 hours.

The next cause of mortality is birth accidents, and Dr. Falls has covered that so thoroughly that I shall not say much about it. There is one thing I would like to mention, that is that cerebral hemorrhage is not thought any more to be caused by indifferent obstetrics. It was very unfortunate that for years when cerebral hemorrhage occurred we were always inclined to think that it might have been due to something for which the obstetrician was at fault. We now know that such is not the case and that it happens in certain babies if the pathologic condition is there. Cerebral hemorrhage is very difficult to diagnose; I find it one of the hardest things I know of. It seems to me with cerebral hemorrhage three things must be demonstrated; first, convulsions; second, cyanosis, and third, flac-

idity followed by spasticity. A spinal puncture is not much help, because we now know that many babies will have some cells normally in the spinal fluid, and the fact that some blood is found does not prove that these children have a cerebral hemorrhage. As to treatment, we are much more conservative than we used to be. We feel that if the baby is put at rest, given ample oxygen and given a chance to rest and recover, it has a better chance. There is considerable argument as to whether spinal puncture should be used; certainly in some instances it may relieve the pressure, but in the majority of instances it may harm more than help. Most obstetricians give vitamin K to them, but there is no evidence that it is on a hemorrhagic disease basis.

The third factor is malformation. There are three types of malformation common in the newborn. Those are the nervous system, the cardiac system and the gastrointestinal system. The nervous system we can dismiss, because they are perfectly obvious, and should be placed in the hands of the neurological surgeon. As far as the cardiac system is concerned, I would like to call to your attention the fact that while it is difficult to diagnose these conditions in the newborn period, there are three conditions that should be sought-for. Those are, double aorta, where the esophagus is encircled by two vessels. Here the child will have a brassy cough almost on the first day, will have difficulty in taking food and spells of cyanosis. The sooner the smaller one of those vessels is ligated the better. The second condition is tricuspid atresia. If it is associated with an intraventricular septal defect and an open ductus, the child will stay alive as long as that ductus stays open, but as soon as the ductus closes it is incompatible with life. So if a child is born cyanotic, with a systolic murmur, and a lateral x-ray shows enlargement posteriorly with a left axis deviation by electrocardiogram, you are probably dealing with that type of stenosis which should be taken care of as soon as possible. The last one is the infantile type of coarctation of the aorta. Unless there is an associated cyanosis, which there may not be unless there is another defect, it is rather difficult to diagnose. There should be, of course, an absence of femoral pulsations but they are occasionally present. There is a difference in blood pressure between

the upper extremities and the lower, but this is seldom thought of unless there is something to attract your attention such as cyanosis. If you do have these, it must be considered, because like the others, as soon as the ductus closes it is incompatible with life and the child will die. So if possible the diagnosis should be made early.

Lastly, there are the gastrointestinal malformations in which one sees the cardinal sign of vomiting, and absence or change of color in the stools. If this occurs in the esophagus there will be immediate vomiting; if it is further down there is vomiting later. The inability of the child to pass meconium will always cause distention, so that should always make us think of this type of disturbance. A very interesting point was made in the last year by Wasch and Marck, who showed that our ideas of how soon air enters the gastrointestinal tract were wrong. The child's complete gastrointestinal pattern may be shown by a flat plate of the abdomen within 18 hours after birth. If we suspect such a thing a flat plate of the abdomen will show the distention of the bowel above the obstruction and operation may be performed within the first 24 hours of life.

Those three things I have mentioned will take care of 85 per cent of the mortality we find in the newborn period. Of the remainder, the only

one of any consequence is infection, and that in our experience is 6.1 per cent. Infections are seen so infrequently nowadays that we are inclined to think they do not occur, but we should always suspect infection in the newborn if there is failure to gain, a fever of over 101° or jaundice. Remember that jaundice in the newborn may be due to infection and not a blood disturbance.

Which brings up the last condition, blood disturbances, which we have found cause only 2 or 3 per cent of the mortality in the newborn. I might say that hemorrhage in the newborn is almost always due to infection and not due to prothrombin deficiency. So vitamin K administration will be inadequate; and some type of antibiotic should be given. As far as hemolytic disease of the newborn is concerned, all I would like to say is that I think it is an obstetrical problem. If a child is going to be born and it is obvious it may suffer from some hemolytic disease, it should be born in some hospital where it will have adequate care by appropriate blood therapy.

Dr. Adams: If the obstetrician, the anesthetist, and the pediatrician fail, the question comes under the scrutiny of the pathologist. The pathology of the neonatal period is exciting increasingly extensive interest, and Dr. Joseph Boggs will discuss this matter.

## The Pathology of Neonatal Death

**Joseph D. Boggs, M.D.**

Dr. Sanford has reviewed the causes of death in the Chicago area. I would like to show a slide similar to his which includes a picture of the United States as a whole. This information was taken from the 1944 records of the United States Bureau of Vital Statistics. The shaded areas represent prenatal and natal causes of death. I would like to illustrate that among premature infants, 86% of all deaths fall into the classification of prenatal and natal causes. The other causes, influenza, pneumonia, dysentery, blood dyscrasias, etc, are a very small portion of the total. The various states vary widely in statistics and also in the completeness with which they report births. These variations ob-

viously affect the probability of the reported rate of deaths.

The most frequent cause of death in the neonatal period as has been stressed this afternoon is anoxia. Anoxia is the most frequent cause of death before birth, during labor, and in the neonatal period. General factors commonly precipitating anoxia are the following: 1. Lowering of the oxygen in the placental circulation, 2. Alteration of sensitivity of the infants respiratory center (as by morphine), 3. By reduction of the oxygen bearing blood to the infant and, 4. By reduction of the CO<sub>2</sub> — O<sub>2</sub> exchange within the infants lungs.

Anoxia, as Dr. Papper has stressed, severely alters metabolic activity of the cells. The cell membrane no longer acts as a barrier to the shift of electrolytes. Carbohydrate utilization is altered. The enzyme systems are altered with an alteration of pH. As early as 1913 Cannon demonstrated in the cat that different cells have different responses to anoxia. Therefore, certain values in the serum, particularly electrolytes and pH, may not adequately evaluate the electrolytes and pH of a particular cell type in a particular organ. A pH of 7.45 in the serum may not adequately represent the pH of the fluid in the cells of the brain or the liver. Our sometimes considered to be careful measurements are in actuality rather crude in evaluating specific cellular alterations.

The human organism in the newborn is physiologically and anatomically immature. Anatomic and functional immaturity in the newborn kidney, liver, lungs is well documented in the newborn period. Minor alterations as seen by the pathologist assume a much greater importance than if they are seen in later life. The pathologic changes seen at autopsy when an infant dies of anoxia are often slight. If the infant dies rapidly or abrupt oxygen deprivation no abnormality may be found at autopsy. If there has been a long period of anoxia in the mother with shock and subsequent rise of the blood pressure then severe edema and congestion in all of the viscerae of the infant may be found. Prolonged anoxia may produce numerous small hemorrhages, particularly prevalent in the thymus, adrenals, brain, and in the submesothelial and submucosal layers. In babies born after premature separation of the placenta, petechial hemorrhagic areas and severe visceral congestion is frequently seen. The uterine contractions force large quantities of blood into the fetal circulation from the placenta.

The next slide is shown to demonstrate the severe damage which may occur with a long-standing relative anoxemia. This is a picture of a heart with an anomalous left coronary artery arising from the pulmonary artery. The oxygen saturation on the right and left sides of the heart before the child is born is essentially equal. This is the right ventricle of the heart and here is the anomalously opening coronary artery behind a pulmonary valve cusp. Beneath this, note

the very thin translucent endocardium lining the right ventricle. One can see the myocardium beneath it. This portion of the heart is being supplied by blood from the aorta which carries sufficient oxygen. However, in that part of the heart supplied with blood from the pulmonary artery, the blood from which has a lower oxygen tension, there is a considerable difference in appearance. The next slide is a picture of the inside of the left ventricle of the same heart. Note that the endocardium here is severely and diffusely thickened resembling a piece of leather. The inner myocardium has been replaced by fibrous and elastic tissue. We know that this change is not so marked in the newborn period but rapidly progresses causing death in weeks or months. These pictures are shown to illustrate how severe a change can occur in tissue which is deprived of oxygen.

The congenital heart lesions which cause death in the neonatal period are shown in the next slide. These cardiac anomalies again have anoxia as a mechanism producing irreversible changes and death. Dr. Sanford mentioned double aorta, simple tricuspid atresia, and infantile coarctation. Pulmonary atresia, biloculate heart (which oftentimes may function into early infancy), aortic atresia, and transposition of the great vessels without ventricular septal defect are other anomalies seen producing early death.

The development of respiratory difficulties in babies delivered by caesarean section is well known. Often there are large amounts of aspirated fluids in the lungs when these babies come to autopsy which has interfered with oxygen exchange. Another factor which may contribute to anoxia in babies born by caesarean section is the loss of blood—as much as 100 cc from the placenta which the baby may not receive when born by section. In normal deliveries this blood is expressed by the uterus into the fetal circulation. Hyalin membranes are sometimes seen in the lungs of babies born by caesarean section.

Intracranial hemorrhage is a finding which pathologists see not rarely in babies who die in the newborn period. If force is suddenly applied to the head or applied unequally to the head a tear in the tentorium cerebelli may result. A tear in the tentorium is probably not lethal unless it extends into the inferior sagittal sinus or lateral sinus. Hemorrhage then occurs, the cere-

bellum is compressed and the baby dies. Small subarachnoid petechial hemorrhages are occasionally encountered resulting from anoxia.

The abdominal viscerae may be damaged by trauma at birth and cause death. This is an uncommon finding and when it does occur is usually seen in the liver or spleen. We have recently seen two ruptured spleens in patients with erythroblastosis. This condition was not considered to result from birth trauma as a primary cause.

Dr. Sanford has spoken of various factors producing intestinal obstruction and death. One other anomaly which should be mentioned is tracheo-esophageal fistula and related anomalies of the esophagus. Usually in these infants the esophagus ends in a blind pouch and either the upper or lower pouch is connected with the

trachea. If the proximal blind segment of the esophagus communicates with the trachea the infant aspirates ingested feedings. If the distal segment of atretic esophagus communicates with the trachea air passes to the intestine and intestinal contents pass to the lungs. This anomaly, although rare, must be considered by the physician for its early recognition offers the only hope for successful surgical repair.

Blood Rh factor incompatibilities producing fetal erythroblastosis and neonatal death although familiar to all must be mentioned in a discussion of this type. This and other interesting disease processes are seen as a cause of neonatal death many of them quite unusual. Unfortunately time does not permit mentioning many of them.

## Question and Answer Period

Dr. Adams: There are a number of questions here, probably more than we can handle, but we take what we can. Here is one directed to Dr. Searles: "Should epinephrine and pitressin be avoided when using cyclopropane or ether?"

Dr. Searles: Epinephrine and pituitrin should be avoided when using cyclopropane as these agents sensitize the cardiac musculature and set the stage for a serious arrhythmia. Pitocin, however, is a safe drug to use and can be substituted for pituitrin.

Dr. Adams: I think we will call on Dr. Sanford for this: "Does the x-ray or fluoroscope show any particular pattern in hyaline membrane of the lung?"

Dr. Sanford: So far as I know, it does not. Of course, if there is an atelectasis it can be seen, but there is no way of differentiating by the x-ray or fluoroscopy which is present.

Dr. Adams: Dr. Falls, in terms of fetal mortality do you believe the cesarean section rate in Illinois is too high or too low?

Dr. Falls: I do not think that one can predicate what should be done in delivering a baby on any statistical basis; rate of section over rate of forceps extraction, because so many things enter into the equation. When I am teaching students about cesarean section I say there are two things you want to know: first, there are

too many cesarean sections being done; second, there are not enough being done. I mean by that, many times a cesarean section should be done and is not done, and a result that baby is lost. On the other hand, there are other cases where the baby would be all right, and cesarean section was done because the obstetrician gets jittery, is not sure of his ground, and is not quite sure of the condition of the baby or the patient, and in order to be free of criticism, he may feel he is able to do a cesarean section, that most of these babies get along all right and he will therefore take the easiest way out, and not sweat it out. It is the keynote of obstetrics to have sufficient courage to put on the one side the dangers of section everything being considered, for the baby and for the mother; and the dangers of delivery from below for the two patients, and then whichever weight bears down heaviest on the scale, choose that method. I do not think we should say we always do a cesarean section when the heart rate gets up to 160 or 170; that may not be the thing to do at all. On the other hand, that might be an indication for section. It is only by weighing all the facts in a given case and getting them into focus that we can determine the best thing to do. All I can say is we pay no attention to statistics. If we think we can do the baby and the mother good

we do not care about the effect on our statistics. We recently had a patient with acute dilatation of the heart on whom we did a section although the Medical Service said we could not do it. We did the cesarean with the mother sitting almost straight under pure oxygen given with an anesthetic mask, and both the baby and mother survived, although we did not expect that the mother would.

We should divide out statistics into two groups, preventable and non-preventable deaths. If a pregnant woman gets hit in the street by an automobile, it is not the obstetrician's fault. We should think of these deaths as preventable or not preventable.

Dr. Adams: Dr. Searles, please give your opinion on air locks and similar resuscitative devices now in use.

Dr. Searles: Air locks are still in the realm of experimental gadgets as far as the administration of oxygen and air are concerned. They enjoyed a wide popularity for a short time, but I would rather defer my opinion on their value. So far as other devices are concerned, those that can give either oxygen or suction seem to be popular. The problem of how much pressure should be used is answered by giving a minimal pressure which will not damage the alveoli of the lung.

Dr. Adams: Dr. Falls, I will ask you to consider two questions; one, the relation of childbirth without anesthesia or analgesia to neonatal mortality; if anesthesia is avoided is the baby's chance better, in other words? Another question, should the cord be milked? Can oxygen be passed through the cord to the baby after birth?

Dr. Falls: We went through the era of twilight sleep and of spinal anesthesia and these are being given up; not because of the anesthetic effect because that is satisfactory. But it results in about 80 per cent forceps delivered because these women cannot deliver themselves, and therefore is not advisable. Local anesthesia supplemented by light general anesthesia, demerol or some of the barbiturates, may be the best answer. The point that a good many people do not understand is that the mechanism by which a baby is born normally, is one of irritation. We think that is physiologically explained by the concept that the pelvic sympathetic ganglia around the cervix, Franhürhauser plexus, when

irritated stimulates the posterior lobe of the hypophysis to generate its hormone which is thrown into the blood and produces labor pains. We are simply concerned with the relief of pain when giving anesthesia in most other surgical conditions. In obstetrics we are concerned with relief of pain and at the same trying to keep active a mechanism which depends upon irritation and pain for its continuance. So you have to compromise. We have to relieve as much of the pain as possible in ordinary labor, without making it necessary to apply artificial force to deliver the baby. The more nearly you can get along without any anesthesia the better off you are.

I would like to say a word about preventing too rapid labor. I think more babies die of too rapid labor than because of slow labor. Therefore, whenever a patient's pains are coming too frequently and too strong, that should be combatted by general anesthesia to offset the excess of oxytoxic present in the blood in these cases.

I think as long as the placenta is attached, and you give the mother oxygen, you can get a certain amount of oxygenation through that. But the trouble is, when the uterus contracts and the sinuses are closed off, the oxygen does not get into the placenta and therefore cannot get to the baby. So I do not think we can do very much there. But I think it is important, if the baby's heart tones begin to indicate anoxemia, either by being too rapid or too slow, to give oxygen to the patient unless she is having very strong pains, in which case deep anesthesia to stop contractions and abundant oxygen should be given concomitantly.

Dr. Searles: There is also the question of whether the baby should be put on the patient's abdomen. There is the possibility that the baby may get less blood because the blood must flow uphill against gravity.

It might also be well to point out that the infant establishes its own oxygen supply with the first cry and that factors such as anesthetics which unduly delay this process necessarily deprive the infant of oxygen. This, of course, is especially true after the cord is clamped.

Dr. Adams: Dr. Sanford, what are the causes of death in the neonatal period of infants born of diabetic mothers? Does it make any difference whether the diabetes is controlled or uncontrolled?

Dr. Sanford: The baby born of a diabetic mother presents a very interesting syndrome. First, it is considerably overweight, and most of the weight seems to be edema fluid, because in the first few days after birth, the baby will lose as much as a pound or a pound and a half of weight. If these babies die autopsy will show immense erythropoiesis. This is shown by the cord blood, which will show large numbers of nucleated red cells, almost as many as are seen in hemolytic disease. If the diabetes in the mother is controlled by giving insulin two or three hours before delivery, the baby may be born with hypoglycemia. To control this, 25 to 50 per cent of glucose may be given intravenously or by mouth immediately after delivery. I think the main thing in the diabetic baby is to give

plenty of oxygen and give it a chance to get rid of the fluid. Priscilla White gives endocrine substances to the mother and also to the baby after birth, and she believes they have lowered their mortality. I think we all agree that controlling the diabetes in the mother will reduce the mortality of the half by half.

Dr. Adams: Dr. Searles, here is a question asking about the effect of Naline.

Dr. Searles: Naline is N-Allylnormorphine hydrochloride and is used to counteract the respiratory depression due to morphine and its derivatives. It is useful when there is a profound respiratory depression.

Dr. Adams: I should like to speak for the Society, I am sure, and for the audience, in thanking this Panel and Dr. Papper for a very instructive afternoon.

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## THE AMERICAN CONGRESS OF PHYSICAL MEDICINE AND REHABILITATION

The 32nd annual scientific and clinical session of the American Congress of Physical Medicine and Rehabilitation will be held September 6-11, 1954 inclusive, at the Hotel Statler, Washington, D. C.

Scientific and clinical sessions will be given September 7, 8, 9, 10 and 11. All sessions will be open to members of the medical profession in good standing with the American Medical Association.

In addition to the scientific sessions, annual instruction seminars will be held. These lectures will be open to physicians as well as to therapists, who are registered with the American Registry of Physical Therapists or the American Occupational Therapy Association.

Full information may be obtained by writing to the executive offices, American Congress of Physical Medicine and Rehabilitation, 30 North

Michigan Avenue, Chicago 2, Illinois.

## TENSION HEADACHE

We believe that the term tension headache should be limited to headache occurring in relation to constant or periodic emotional conflict, of which the patients are usually partially aware. Such an emotional state may induce headache by producing changes in the calibre of the cranial vessels and concomitant spasm of the skeletal muscles of the head and neck. The background and pathophysiologic mechanism for this headache are similar in many ways to the migraine syndrome. However, tension headaches have no prodromata, are usually bilateral, occipital or frontal, and may be accompanied by a variety of associated signs including anxiety, nausea, and vomiting. Frequency and duration are variable. *Naomi de Sola Pool, M.D., and Arnold P. Friedman, M.D., Observations on the Treatment of Headache. J. A. M. W. A., February, 1954.*

# Osteomyelitis of the Spine From Urinary Infections

Robert D. Mussey, M.D.  
Urbana

Pyogenic osteomyelitis of the spine as a definite entity has been well described by Kulowski<sup>10</sup>, Compere and Garrison<sup>5</sup>, Turner<sup>14</sup>, Guri<sup>7</sup>, and others. The infective organism usually is staphylococcus aureus<sup>4, 10, 14</sup>. Few of these cases have been known to be secondary to urinary tract infections. Kulowski found sixty cases of pyogenic osteomyelitis of the vertebrae among 1,500 cases of pyogenic osteomyelitis, an incidence of 3.94 per cent. In twenty-three of the sixty cases an infection was found which probably was primary to that in the spine. Only one of these twenty-three infections was in the urinary tract, a prostatic abscess.

Kretchmer and Ockuly<sup>9</sup> in 1935 reported one case of vertebral osteomyelitis secondary to a urinary tract infection. Kulowski reported one case in 1936; Kusonoki<sup>11</sup>, one in 1938; Schein<sup>13</sup>, one in 1940; Deming and Zaff<sup>6</sup>, three in 1943; Hurwitz and Albertson<sup>8</sup>, one in 1950; and Alderman and Duff<sup>1</sup>, one in 1952. This totals nine cases which have been found in the literature to date. In addition, Walsh<sup>15</sup> has one case which is unreported. Two case reports follow.

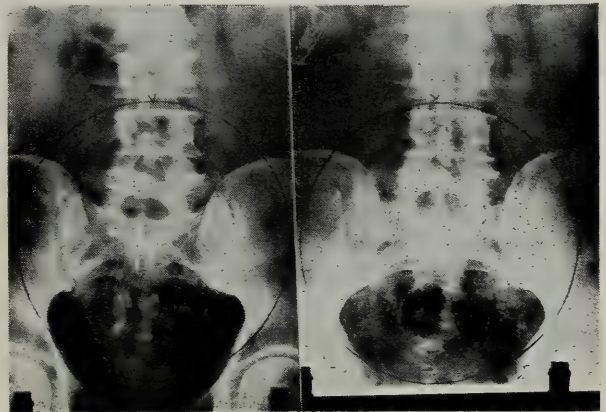
*Case 1.*—E.E.R., a blacksmith, was first seen at the Carle Hospital Clinic in 1946 at age fifty-five for recurrent backache of a static nature. X-rays showed moderate osteo-arthritis of the spine and clear sacro-iliac joints, although the x-rays were not of sufficiently good technique for satisfactory reproduction.

In 1947, he was again seen for chronic epididymitis, subsiding orchitis, and early prostatic obstruction. A cholecystectomy was performed for chronic cholecystitis and cholelithiasis.

On July 23, 1949, his urinary bladder was catheterized and cystoscoped elsewhere because of urinary obstruction. Two days later he developed chills, fever, and severe pain in the right sacro-iliac area. A transurethral resection of the prostate was performed on August 4, 1949. This relieved the obstructive symp-

toms, but the back pain continued unabated and he was bedfast.

He was admitted to the Carle Memorial Hospital on August 24, 1949, with severe pain in the lower back and posterior thigh area. Upon examination, the oral temperature was 103° F. There was moderate tender-



**Figure 1.** The view on the left, taken October 24, 1949, shows beginning destruction of the right sacro-iliac joint which appears fused on the roentgenogram on the right, taken November 24, 1950.

ness in the right flank, marked tenderness in the right sacro-iliac joint, and slight deep abdominal tenderness in the right lower quadrant without muscle spasm. The right hip was held in 150° flexion. Hip motions were otherwise normal.

The erythrocyte sedimentation rate was 148 millimeters in forty-five minutes by the Westergren method. The hemoglobin was 6.95 grams per 100 cubic centimeters, and the erythrocyte count was 2,720,000 per cubic millimeter. Urinalysis showed a trace of albumin and a full field of leucocytes. A urine culture was positive for the coli-aerogenes group, e.g. escherichia coli or aerobacter aerogenes. X-rays showed osteoporosis of the right sacro-iliac joint (*Figure 1*). A blood culture taken on admission was subsequently reported as showing no growth of organisms. The clinical diagnosis was a psoas abscess and possibly an acute pyogenic arthritis of the right sacro-iliac joint.

On August 27, 1949, a small psoas abscess on the right was opened surgically. Organisms of the coli-aerogenes group were cultured from the pus obtained.

The patient was treated by bed rest, traction, and chloramphenicol and improved. On September 13, 1949, a right orchidectomy was done for a chronic painful testicle of five years' duration. About this time mild pain developed in the mid-lumbar area.

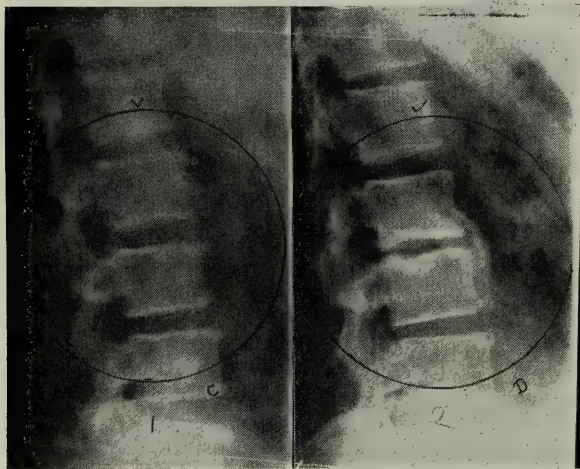
Presented as a membership thesis before the Chicago Orthopedic Society, Chicago, Illinois, March 14, 1952.

From the Department of Orthopedic Surgery, Carle Memorial Hospital and Carle Hospital Clinic, Urbana, Illinois.

Mr. R. was dismissed from the Hospital on September 25, 1949. Except for elevation of fever twice, his temperature was normal from then until he was readmitted on October 20, 1949, for continued back pain. He had occasional fever up to 100° F. and poorly localized back tenderness. On November 31, a body cast was applied for a diagnosis of probable osteomyelitis of the spine. He was dismissed to return in two weeks.

The patient sought care elsewhere, where later x-rays confirmed the diagnosis of osteomyelitis of the spine, and a double spica cast was applied to both knees. The patient gradually removed this bit by bit at home and returned to us on May 4, 1950, with his cast off. X-rays taken then showed fusion occurring between the second and third lumbar vertebrae and obliteration of the right sacro-iliac joint. Urinalysis was normal. The erythrocyte sedimentation rate was within normal limits, as was the red blood count. A new cast was advised but refused, and Mr. R. went home the next day. Because of discomfort, he returned in three days for the cast, which was finally removed on August 7, at which time x-rays showed an apparently solid fusion.

The patient was last seen on November 24, 1950, at which time there was no back pain. X-rays (Fig. 2) showed an apparently solid fusion. He stated in a letter written on June 28, 1951, that he was doing well but was, as yet, unable to work.



**Figure 2.** The roentgenogram on the left, taken September 14, 1949, shows no more than osteoarthritis of the superior surface of L-3 with a suggestion of early destruction while that on the right, taken November 24, 1950, shows an apparently solid fusion.

**Case 2.**—M.F., a white male, age sixty-one, was first seen at the Carle Hospital Clinic on August 11, 1950, with bilateral painful hallux rigidus of marked degree, the pain being at the plantar surface of the interphalangeal joints. A history was obtained of three urinary bladder and urethral operations in 1941 and 1942 for a post-gonococcal urethral stricture. The patient stated that one-half grain of morphine was

always necessary to relieve his pain but that he could stop morphine at will.

A Keller procedure, postponed because of a concomitant iritis, was performed on both great toes on October 11, 1950. Convalescence was uneventful except for an exacerbation of peptic ulcer symptoms which had plagued the patient intermittently for twenty-five years. He was able to tell that the dosage of morphine administered postoperatively was less than one-half grain.

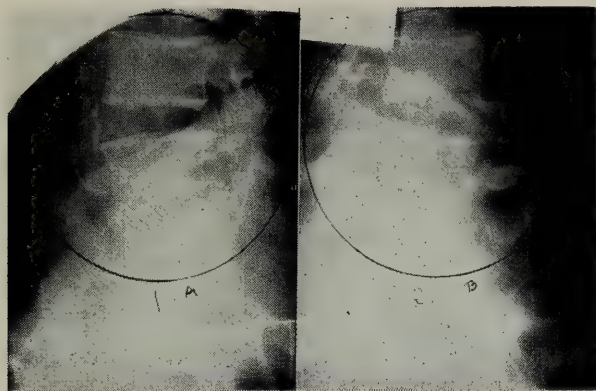
Mr. F. was dismissed from the hospital walking on October 26, only to be readmitted three days later with urinary symptoms, chills and fever. This trouble responded satisfactorily to antibiotics, and he again was dismissed six days later.

He was readmitted to the Hospital for the third time on November 12 with an acute urinary retention which necessitated urethral dilatation under anesthesia. During this convalescence he required considerable amounts of morphine and was emotionally unstable. He was discharged after a five-day stay.

Mr. F. returned to his barbering trade which he plied until December 30, 1950. At that time he was forced to stop because of increasingly severe back pain which began suddenly eleven days previously. He was readmitted to the Hospital for the last time on January 2, 1951, with a fever of 102° F. and diffuse low back pain without psoas spasm. Marked abdominal distention was present. Psoas irritation first became evident on January 8, and tenderness seemed to be localizing to the fourth lumbar vertebra on the next day. A presumptive diagnosis of acute osteomyelitis of the lumbar spine was entertained and a spica cast recommended. Other diagnoses had been considered sufficiently prior and subsequent to this time to have obtained an intravenous urogram, a colon roentgenogram, and a spinal puncture. It was not until January 25 that the patient would agree to immobilization. Only after this was done did his abdominal distention decrease. Recurrent urinary distress bothered the patient throughout his hospital stay. Low doses of bromides produced bromidism after eleven days toward the end of his hospitalization.

During this hospitalization the urine intermittently showed albumin of varying degree and leucocytes. One urine smear showed Gram-negative rods and two revealed no bacteria. One blood culture was negative. The erythrocyte sedimentation rate was consistently moderately elevated, the leucocyte counts inconsistently elevated, and the hemoglobin and erythrocyte determinations within normal limits. The cerebrospinal fluid revealed a total protein of sixty-five milligrams per 100 cubic centimeters, a quantitative Kahn of two, and a gold curve slightly elevated in the middle. There was no evidence of block. Blood serology was negative.

The patient was very difficult to handle, and his wife was quite unco-operative, having no insight into



**Figure 3.** The x-ray on the left, taken January 4, 1951, shows an apparently normal interspace and adjacent L-4 and L-5 vertebrae. That on the right (reversed), taken February 21, 1951, shows early destruction of the under surface of L-4.

the personality of her husband. Both the patient and his wife pleaded and cried daily to have the cast removed. This was finally done on February 21, 1951. In the short time between the removal of the cast and the time Mr. F. left for home the same day, a roentgenogram was taken which revealed changes compatible with osteomyelitis of the adjacent surfaces of the fourth and fifth lumbar vertebrae (Fig. 3). The patient has not been seen since, although his wife stated by phone in April, 1952 that his back had not bothered him for about nine months.

### DISCUSSION

Of the eleven cases collected and reported herein, all were males, all other information regarding one case being unknown. The youngest of these ten was forty-five years of age and the oldest seventy-one years of age. Surgery or instrumentation consisting of cystoscopy or urethral dilatation was performed in nine cases, in the lower urinary tract in eight cases, and in the renal pelvis in one case. In the tenth case the osteomyelitis appeared spontaneously after a proved urinary infection of several months' duration. The onset of back pain was from the next day to ten weeks following the operative procedure in the nine cases with six of these being within eight days.

Roentgenograms became positive in from three weeks to three years after the onset of back pain in the eight cases in which the time relationship is known. Undoubtedly positive x-ray findings might have been found earlier in some cases. The cervical area was involved in two cases, the thoracic in four, and the lumbar in four. In only three patients were more than two vertebrae involved, three, four and five respectively being affected in these.

In most of these cases the causal relationship of the urinary tract infection to the osteomyelitis is only presumptive. In only three of the ten was a confirmatory culture of both the vertebral abscess and the urine obtained, one being *escherichia coli*, another *pseudomonas aeruginosa*, and the third either *escherichia coli* or *aerobacter aerogenes*. In a fourth, urinary and blood cultures yielded the same organism, *proteus vulgaris*. Urinary cultures in a fifth and sixth showed *proteus vulgaris* and *pseudomonas aeruginosa* respectively. Blood culture in a seventh was positive for *escherichia coli* and a non-hemolytic streptococcus. In an eighth, a staphylococcus aureus and a large Gram-positive bacillus were obtained from the abscess. Contrary to the usual case of pyogenic osteomyelitis of the spine, the staphylococcus aureus organism is rarely the infective agent when a urinary infection is primary.

The method of spread of the infection from the urinary tract to the spine is most readily explained by the vertebral system of veins described by Batson<sup>2,3</sup>. This system is composed of a set of valveless, thin-walled venous channels which are primarily perivertebral but which have connections with the prostatic plexus of veins, veins of both bony girdles, epidural veins and veins of the cranial cavity as well as with the major venae cavae of the extremities, veins of the thoraco-abdominal wall, and veins of the head and neck. This whole system is connected to both vena cavae.

Deming and Zaff suggest that many patients with typhoid fever and brucellosis have infections of the urinary tract from these organisms. They believe that Batson's veins may be incriminated in the spread of typhoid fever, undulant fever, and gonorrhea to the vertebral column.

Many cases of pyogenic osteomyelitis of the spine which are secondary to infections such as boils are associated with proved urinary infections<sup>4,14</sup>. The time relationship of some is such that the urinary infection, while following the primary infection, precedes the osteomyelitis. Carson reported four cases of osteomyelitis of the spine following head and neck boils in three and a coccygeal abscess in the fourth. In two which followed boils, the urinary infections antedated the osteomyelitis which was in the lumbar area. It is very possible that the causative organism

in these two patients actually reached the spine from the urinary tract by way of the vertebral system of veins.

Infections of the urinary tract also can spread to the long bones. These undoubtedly are examples of the usual hematogenous spread of infection.

Backache which appears immediately or within a few weeks after surgery of the lower urinary tract in males beyond their midpoint in life should alert the surgeon to the possibility of a complicating pyogenic osteomyelitis of the spine. This is especially true if a urinary infection was present. The backache may be very severe or mild and nagging. The clinical picture may be one of severe sepsis or a chronic, low-grade infection. Paralytic ileus is commonly present if the pain is in the lumbar area.

Should this complication of osteomyelitis be suspected, treatment should be directed toward it before a positive diagnosis can be made roentgenologically. Proper antibiotic or chemotherapeutic agents can be selected for use after the probable organism is isolated from the urine by culture. Adequate immobilization is important as well as general supportive measures.

#### CONCLUSIONS

(1) Pyogenic osteomyelitis of the spine is rarely secondary to urinary tract infection, only eleven cases being collected from the literature, including the two cases reported herein.

(2) Instrumentation or surgery of the lower urinary tract in males beyond the age of forty-five years usually precedes the osteomyelitis.

(3) The surgeon should be cognizant of this

condition and should not delay treatment until roentgenologic proof is obtained.

(4) The method of spread of the infection from the urinary tract to the vertebral column is probably by the vertebral system of veins described by Batson.

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# Drinking Water: Source of Poliomyelitis Infection?

Hugh Macdonald, M.D.,  
Peoria

Poliomyelitis epidemics occur in the summer and fall when epidemics of gastro-intestinal diseases prevail and when respiratory diseases are at a minimum. Therefore, in the light of recent knowledge, it seems advisable to reconsider the possibility that poliomyelitis may be disseminated, in part, by drinking water.

Poliomyelitis virus was found in human feces as early as 1912<sup>1</sup>. During the 1943 epidemic of poliomyelitis in Fort Worth, Pearson and his coworkers<sup>2</sup> made an intensive study of the distribution of the virus in a selected district of the city. By inoculation into monkeys, they tested stools from 524 persons in 180 families for virus. A composite sample of stool was made from the members of each family. Six of 8 households, representing familial contacts, were positive for virus, as were 8 of 45 households containing non-familial contacts, and 2 of 127 households representing noncontacts. In this study virus was not recovered from specimens of water, sewage, flies, ants, cockroaches, or droppings of domestic animals.

Casey and his associates<sup>3</sup>, working in Chicago, reported they recovered poliomyelitis virus from the stools of 8 percent of 104 children from 26 control neighborhoods, from 53 per cent of 101 contact children, and from 11 per cent of 55 non-contact children in the patients' neighborhoods during 1945 and 1946. They calculated that most children in Chicago had probably had poliomyelitis by the fourth birthday. These calculations suggest that an average of 100,000 to 125,000 cases of poliomyelitis occur in Chicago each year. This figure represents 3 to 4 per cent of the total population.

Melnick<sup>4</sup>, in a study of New York sewage, on the basis of 10,000 infective doses in monkeys per 100 grams of feces, estimated that approximately 6 per cent of the population of Manhattan in New York City may have been poliomyelitis carriers in the autumns of 1940, 1941, 1944, and 1946.

Virus may persist in the stools of poliomyelitis

convalescents for from 4 to 8 weeks<sup>5</sup>. Lépine and his coworkers<sup>6</sup> reported the successful, repeated isolation of virus from a child up to 17 weeks after the onset of the disease.

Virus has been shown to remain viable in a stool sample for 10 weeks<sup>5</sup>, and in tap water for 14 weeks<sup>7</sup>. The Lansing virus, suspended in ice cream and kept in refrigerator, has survived for 20 weeks<sup>8</sup>.

In the United States chlorine is the chief agent used to purify drinking water. A combined residual of 0.1 to 0.2 parts per million (ppm) of chlorine<sup>9</sup> is considered adequate to kill *Escherichia coli* (*Bacillus coli*) group of bacteria in 10 minutes. The ten-minute period is the minimum needed for water to pass from the pumping station to the first water consumer in many cities. The chlorine content of public drinking water is measured, usually in 5 to 10 minutes after adding the chlorine, by the Orthotolidine Reagent (OT). This reagent determines both the combined (chloramines) and free uncombined chlorine in one total. By a new method reported in 1944<sup>10</sup> sodium arsenite is added to prevent the color change from the chloramines and only the free uncombined chlorine registers a color change. This test is called the Orthotolidine Arsenite Test (OTA).

Levaditi and his associates<sup>11</sup> in 1931 first demonstrated that chlorine inactivated poliomyelitis virus. They found that 0.4 ppm (OT) chlorine killed the virus in 24 hours.

Kempf and Soule<sup>12</sup> in 1940 found that 0.55 ppm (OT) chlorine did not inactivate poliomyelitis virus after 1½ hours' exposure, although it did inactivate it after 4 hours' exposure.

Ridenour and Ingols<sup>13</sup> in 1946 found that in a suspension of infected spinal cord, after prolonged centrifugation, the virus was not killed by exposure for 10 minutes to 0.9 ppm (OT) chlorine, which also tested 0.10 ppm (OTA) free chlorine. For complete inactivation of virus, they concluded, there must be from 0.5 ppm to 1.5 ppm chlorine residues, measured by Stand-

ard Orthotolidine Reagent, after a ten-minute contact period. This is 5 times as much chlorine as is required to kill Esch. coli.

Furthermore, these investigators demonstrated that the relationship between the inactivation of the virus and the "free uncombined chlorine residual", as measured by the Ortho-tolidine Arsenite Test, is quite definite. In their experiments inactivation was secured in 10 minutes with 0.3 ppm of free uncombined chlorine residuals (OTA) in all instances, regardless of the quantity of organic matter present in the suspension.

Lensen and his associates<sup>14</sup>, working with samples of three different lake waters, two river waters, and one lime-treated well water, confirmed the results of Ridenour and Ingols. In their experiments as little as 0.15 ppm (OTA) free uncombined chlorine inactivated poliomyelitis virus in 10 minutes.

Cities vary in the quality of their water and in the quantity of chlorine added. Table 1 shows the Ortho-tolidine (OT) residuals of 21 cities in 1952. Only four of these cities reported using the Ortho-tolidine Arsenite Test.

TABLE 1  
RESIDUAL CHLORINE IN CITY WATER

	ppm (OT)
Denver .....	0.2
Los Angeles .....	0.2-0.3
Buffalo .....	0.2-0.3
New York .....	0.2-0.6
Evanston .....	0.25
San Francisco .....	0.2-0.4
Peoria .....	0.2-0.4
Chicago .....	0.25-0.62
Baltimore .....	0.4
Philadelphia .....	0.4-0.6
New Orleans .....	0.48
Detroit .....	0.48
Milwaukee .....	0.5-0.6
Houston .....	0.5-0.9
Boston .....	0.5-1.0
Toledo .....	0.6
Duluth .....	0.8
Cleveland .....	1.0
Gary .....	1.0-1.5
St. Louis .....	1.8
Minneapolis .....	2.0

On the basis of the Ridenour-Ingols investigations, most of these city waters would not inactivate poliomyelitis virus in 10 minutes.

Many persons, especially in rural areas, drink

water that is not chlorinated. Not only is this true on the farm, but also in summer resorts, gas filling stations, rural eating places, and children's camps. Table 2 shows the amount of Esch coli group of bacteria contamination of drinking water in rural areas as determined from well water samples submitted to the laboratories of the State Departments of Health of 24 States.

TABLE 2  
COLIFORM BACTERIAL CONTAMINATION  
OF RURAL WELL WATER SAMPLES

	Per cent Positive		Per cent Positive
Ohio .....	70-80	Nebraska .....	41
Iowa .....	70	Colorado .....	40
Illinois .....	66	Rhode Island .....	37
New York .....	65	New Jersey .....	35
Texas .....	60-80	Maine .....	32
Wisconsin .....	60	Michigan .....	25
Mississippi .....	50	S. Carolina .....	25
N. Dakota .....	50	Florida .....	21
Vermont .....	50	Washington .....	20
W. Virginia .....	48	New Hampshire ..	19
Pennsylvania .....	48	Massachusetts ....	12
Indiana .....	48	Idaho .....	10-30

The other State Departments of Health report that data are not readily available (1952)

To determine the possibility of chlorinating well waters, the author added laundry bleach to samples of water from 20 rural wells collected in 7 counties of Central Illinois. Four popular commercial brands of 5.25 per cent sodium hypochlorite solution, laundry bleach, were found to be equal in chlorine content. In 90 per cent of the wells tested, a free uncombined chlorine residual (OTA) sufficient to kill poliomyelitis virus in 10 minutes was produced by thoroughly mixing 3 drops of laundry bleach with one gallon of the clear or only faintly turbid well water. Full data are in Table 3. In 10 per cent of the well waters, which were very turbid, 20 to 43 drops of laundry bleach were required to produce a similar free chlorine residual. Fifty shakes of the gallon jug of water were made after adding the drops of laundry bleach to insure thorough mixing. Such treated water should be allowed to stand at least 10 minutes before drinking.

COMMENT

Trask<sup>5</sup> reported the presence of virus in the nasopharynx during the early stages of poliomyelitis. However, he found that during the early

TABLE 3.  
LAUNDRY BLEACH CHLORINATION OF  
WELLWATER

Well	1 drop to gallon	2 drops to gallon	3 drops to gallon	Remarks
1	OT 1.5	OT 4.0		Clear or
	OTA 1.0	OTA 3.4		faintly turbid
2	OT 0.7	OT 3.5		Clear or
	OTA 0.5	OTA 3.4		faintly turbid
3	OT 1.0	OT 3.0		Clear or
	OTA 1.0	OTA 3.0		faintly turbid
4	OT 1.0	OT 3.0		Clear or
	OTA 0.7	OTA 3.0		faintly turbid
5	OT 1.0	OT 3.0		Clear or
	OTA 0.7	OTA 3.0		faintly turbid
6	OT 1.0	OT 3.0		Clear or
	OTA 1.0	OTA 3.0		faintly turbid
7	OT 1.0	OT 3.0		Clear or
	OTA 1.0	OTA 3.0		faintly turbid
8	OT 0.7	OT 3.0		Clear or
	OTA 0.7	OTA 3.0		faintly turbid
9	OT 0.7	OT 3.0		Clear or
	OTA 0.7	OTA 3.0		faintly turbid
10	OT 0.7	OT 3.0		Clear or
	OTA 0.4	OTA 2.0		faintly turbid
11	OT 1.0	OT 2.5		Clear or
	OTA 0.4	OTA 1.5		faintly turbid
12	OT 1.0	OT 2.0		Clear or
	OTA 0.2	OTA 1.5		faintly turbid
13	OT 0.3	OT 1.5		Clear or
	OTA 0.2	OTA 1.0		faintly turbid
14	OT 0.3	OT 1.5		Clear or
	OTA 0.2	OTA 1.0		faintly turbid
15	OT 0.3	OT 1.5		Clear or
	OTA 0.2	OTA 0.7		faintly turbid
16	OT 0	OT 1.5		Clear or
	OTA 0	OTA 0.2		faintly turbid
17	OT 0	OT 0.4	OT 1.5	Clear or
	OTA 0	OTA 0.1	OTA 0.3	faintly turbid
18	OT 0.1	OT 0.3	OT 1.5	Clear or
	OTA 0	OTA 0.1	OTA 0.5	faintly turbid
			20 drops	
19	OT 0	OT 0	OT 3.0	Very
	OTA 0	OTA 0	OTA 3.0	turbid
			43 drops	
20	OT 0	OT 0	OT 1.0	Odorous,
	OTA 0	OTA 0	OTA 1.0	very turbid

OT: Ortho-tolidine Test

OTA: Ortho-tolidine Arsenite Test

Laundry Bleach: 5.25 per cent sodium hypochlorite solution, such as CHLOROX®, BRIGHT SAIL®, FLEECY WHITE®, and LINCO®

Chlorine contact time: 5 minutes

stages it is almost twice as easy to find the virus in the stools as it is in the nasopharynx.

Because virus is found so frequently in the stools and in sewage, several investigators studied the possibility of filth flies transmitting the disease. They found poliomyelitis virus on several occasions. When the flies were identified, positive results were obtained with specimens consisting predominantly of blow-flies and green-bottle flies. House flies and stable flies were not present in some samples found to contain virus<sup>15,16</sup>.

Although several milk-borne epidemics, characterized by explosive type of onset, have been reported and although the virus can survive in milk for several weeks, it is unlikely that this is a common mode of spread.

The epidemic incidence of poliomyelitis in summer and early fall may be associated with travel and the drinking of contaminated well water at this time. Moreover, many cities permit bathing in lakes that are the source of drinking water. The ingestion of contaminated water while swimming on a crowded beach may be another source of infection.

#### CONCLUSIONS

(1) During epidemics, poliomyelitis virus is found in the stools of persons comprising as much as 6 per cent of the city population, most of whom show no other sign of the disease.

(2) Five times as much chlorine is required to kill poliomyelitis virus as *Esch. coli* (*Bacillus coli*).

(3) The amount of chlorine now added to many city waters is not adequate to kill the poliomyelitis virus in 10 minutes.

(4) It is recommended that city water carries a free chlorine residual of 0.15 to 0.30 ppm (OTA).

(5) Many rural well waters used by the public are contaminated with *Esch. coli* group of bacteria.

(6) Three drops of laundry bleach (5.25 per cent sodium hypochlorite solution), well mixed with one gallon of water, was found adequate for chlorination of the few clear or only faintly turbid well waters tested.

400 Central National Bank Bldg.

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## THE SOVIET PHYSICIAN

The lot of the Soviet physician is not a happy one as judged from a long and detailed study recently published in the Soviet Union by the *Literary Gazette*, the influential and official organ of the Union of Soviet writers. Entitled "Hours and Minutes of the Physician," the article reveals several grave shortcomings in medical work. In the first place, the patient load is so great that not even the official norm of 10 minutes for each can be observed by the physician. Thus, in two cases reported as typical, a physician saw 22 patients in three hours and another saw 26 in three and one-half. Needless to say, careful examination and even civil conversation with the patient are almost impossible. This time is further whittled down by the tremendous amount of paper work that must be done in the form of endless forms and statistics. Thus, of the 180 minutes spent by the first physician, 33 were devoted to listening to and examining patients (an average of one and one-half minutes per person), nine in measuring blood pressure, 56 in reading and filling in case histories and the rest, or about half, on paper work. *Mark G. Field, Workday of the Soviet Physician. New England J. Med, Feb. 4, 1954.*

## MISSED ABORTION AND MISSED LABOR

Intrauterine death of the fetus is followed by decrease of estrogens in the blood. This is easily determined by the Frank-Goldberger blood estrin test or one of its modifications. The Venning and Browne method shows low pregnanediol glucuronide excretion. In such cases, estrogens have been administered for five to eight days with the object of sensitizing the uterus in order to promote spontaneous evacuation of the products of gestation. Jeffcoate has reported successful results in 48 of 55 such cases using this method. Since spontaneous abortion commonly occurs in such cases, some of this success can be regarded as coincidental. Judd, on the other hand, feels that the treatment of missed abortion should be watchful waiting until the uterus spontaneously evacuates its contents. Although there are no reports of any controlled investigation, estrogen therapy may be attempted in such cases without compromising the safety of the patient. It is to be pointed out, however, that low estrogen levels are the effect of the fetal deaths rather than a cause for the failure of labor to occur. The nature of the mechanism which causes this onset of labor still is unknown. *New York J. Med. Nov. 1, 1953.*

# The Northern Illinois Blood Bank

Janice Mae McGowan, M.T. (ASCP) and Paul A. Van Pernis, M.D.

Rockford

In 1951 the Medical Service Committee of The Winnebago County Medical Society conceived the idea of consolidating three hospital blood banks into one large bank which could serve the community blood needs at the lowest possible cost to blood recipients. Blood banks all over the country were contacted for ideas, plans, and methods. The plan adopted after much deliberation was a "blood insurance" plan to provide blood for everyone without any exception. An idea instituted by Dr. Hugh Wilson<sup>1,2</sup> of the Jacob Blumberg Memorial Blood Bank at Waukegan, Illinois, was modified and adopted by The Winnebago County Medical Society.

This plan guarantees to families who make application for membership in the Bank that all of their blood needs will be fulfilled at a minimum service charge (currently \$10) if they agree to have a member of the family give a pint of blood when called upon to do so by the Blood Bank. A unit of blood, then, is the "premium" for their "blood insurance." Applicant

members must give their blood—if they are suitable donors—when called. Membership in the program is lost if no donation is made after a maximum of three calls—postcard or telephone—is made by the Blood Bank. Membership can be reinstated upon reapplication and donation of the "premium" unit of blood.

If there are no medically suitable donors in the family but response is made to the Blood Bank's call, then membership is not lost but retained. The suitability of members as donors is determined by the standards set forth by The National Institute of Health and The Illinois Association of Blood Banks. Non-members are charged \$30 for each unit of blood (\$10 service charge and \$20 penalty fee) but may reduce the cost to \$10 by supplying two donors for each unit of blood received. Thus far such replacement of blood by non-members has supplied about 50 per cent of the blood issued by the Bank. Such replacement donors are given receipts of their donation with a duplicate posted to the recipients account and a third copy sent to the

1. "What's New" — Abbott — issue of May, 1952, page 11
2. J.A.M.A., Vol. 146, 14: page 1331

## BLOOD BANK COPY

### *Northern Illinois Blood Bank, Inc.*

307 NO. MAIN STREET

ROCKFORD, ILLINOIS

DIAL 5-8751

#### REPLACEMENT DONOR'S RECEIPT

NO. MACH.....

HOSPITAL.....

CONTROL NO.....

DATE.....19....

DONOR'S NAME.....

PATIENT'S  
NAME.....

BLOOD  
NO.....

TRANS.

DATE.....

BY.....

AMT. TO BE CREDITED TO  
PATIENT'S ACCOUNT

FOR THE BLOOD BANK

BY.....

DONOR'S SIGNATURE

\$.....



The Northern Illinois Blood Bank, incorporated not for profit under the laws of the State of Illinois, took its first ten donors on December 1, 1952. This was made possible by loans from members of the Winnebago County Medical Society to be repaid when possible without interest. This amounted to \$12,100. In addition, approximately \$7,500 for major equipment was carried as a non-interest bearing loan by a local laboratory supply firm.\*

We began operation with one technician, one office clerk and receptionist, and the help of the Medical Society executive secretary. Technical advice was given by the pathologists of Rockford. At present, we have an M. D. General Manager, two technicians, a receptionist, and a bookkeeper who form an adequate staff.

The control of the Blood Bank is vested in a board of directors composed of six physicians appointed by the county Medical Society and one layman from the boards of trustees of each of the participating general hospitals in the city of Rockford. One physician from the active staff

\*Ginders, Incorporated.

Four months after beginning operations we were inspected and approved by The National Institute of Health, thus allowing us to ship blood across state boundaries. We are also approved by The Illinois State Department of Health for Serology tests for syphilis and for blood typing. We hold institutional memberships in The American Association of Blood Banks and The Illinois Association of Blood Banks.

We have co-operated with eighteen blood banking agencies in supplying blood to persons hospitalized in Winnebago county and to members of The Northern Illinois Blood Bank hospitalized in other parts of the United States. This is sometimes done by the actual shipment of blood by air and under refrigeration as in a recent shipment to Philadelphia Doctor's Hospital, or sometimes by transfer of paper credits and debits between banks balancing accounts in cash, or with blood at periodic intervals.

**NORTHERN ILLINOIS BLOOD BANK, Inc.**  
307 North Main Street Dial 5-8751  
ROCKFORD, ILLINOIS

**DONOR'S IDENTIFICATION**

NAME

ADDRESS

TYPE

Rh

DATE \_\_\_\_\_

For The Northern Illinois Blood Bank, Inc.

Date of Donation	DEPENDENTS	Age



recovered poliomyelitis patients from whose blood gamma globulin may be processed.

We have tried to obtain a contract with the American Red Cross to bleed volunteer donors for defense purposes. These hopes were not fulfilled because of the recent policy of closing many major Red Cross bleeding centers although the local Red Cross Chapter was and is co-operative in our venture.

We are gradually enlarging our plasma and serum salvage program from outdated and unsuitable blood as well as offering "pediatric" size blood units, resuspended cells, and a typing service to hospitals who do not have the various and less common typing sera available to them.

As soon as our remaining debt is cleared we

contemplate lowering the "service charge" or cost of blood since we are a non-profit institution.

#### SUMMARY

We believe The Northern Illinois Blood Bank, Incorporated, offers a very inexpensive plan to cover the blood needs of every individual in any community and that it demonstrates the ability to provide for the special blood needs of such programs as the recent defense program and poliomyelitis program. To accomplish this a nucleus of civic-minded persons who are willing to work is needed. Blood Banking is The Practice of Medicine. It should be done by and controlled by the doctors of medicine.

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## Medical Service and Services

**Willis I. Lewis, M.D.,  
Herrin**

**President, Illinois State Medical Society**

To serve as president of the Illinois State Medical Society is at once a privilege and a burden. It is a burden in the sense that it takes a great deal of time away from home and office and entails much travel and effort to learn many new activities which would not otherwise be necessary.

But it becomes a privilege when its many compensations are considered — the opportunity to serve profession and public, to contribute what one can to the progress of medicine, to help in the continuing struggle to keep medicine free for the people — and to participate in ceremonies like this. I have been present at several such rites as you have just witnessed, the presentation of a Fifty Year Club pin and certificate to a physician who has spent half a century in the practice of medicine, but it has never yet lost its heart-warming character. It is a pathetically inadequate gesture in contrast with the achievement it marks, but what could any one do that would be an adequate testimonial to the devotion of the last fifty years? That pin and paper can never be anything but a symbol, a reminder, a string-around-the-finger, completely

disproportionate, merely suggesting what is in our hearts.

There is another aspect of this gathering which is equally inspiring to me — the postgraduate meeting itself. It illustrates two fine things in medicine — the duty imposed on every physician to make his knowledge and experience available to all others, and the duty of every physician to keep himself up to date on the leaping advances of modern medicine. Both these functions form the basis of the ethical duty imposed on every physician to do his utmost for every patient, not only his own, but those of others — in brief, to do his best for the welfare of humanity.

This meeting, I repeat, well illustrates that phase of the physician's responsibility in the quality of the teachers who have taken time from their university duties to come down here to present their ideas, and in the character and size of the audience who will go back to their patients refreshed and stimulated. The general public little realizes the extent to which individual physicians', both teachers and practitioners, carry out these functions from year to year, yet it is the general public which benefits in the long run and importantly from these efforts.

If every physician stopped learning at the time he left medical school, the practise of medicine

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Delivered at the Postgraduate Conference in Kewanee, Illinois, April 15, 1954.

would be in a sad way and the health of our people would be sadder. They would be denied the benefits of the enormous annual increase of medical knowledge gained through the research work of thousands of doctors in laboratories throughout the world, backed by the work of other thousands of chemists and biochemists, physicists, engineers, agronomists, veterinarians and others. Medicine draws from all branches of science help in its fight to benefit mankind, the highest form of life. But their contributions would be futile if they were not made available through meetings like this.

And that leads me to medical organizations — much misunderstood, much criticized, much accused of conspiracies and plots and sinister cartels, but still continuing faithfully to carry out its basic purpose — that of providing the mechanism and the finances for postgraduate medical education. The prime purpose of every medical organization, I think, will be found stated in its constitution as that of disseminating medical knowledge. That is why most organizations immediately establish magazines, hold meetings and arrange for sessions such as this. The practising physician must be kept up to date.

But postgraduate education is not the only unappreciated function performed by organized medicine for the benefit of the public. I cannot speak in detail of the work of other state medical societies, but I am familiar with the program of the Illinois State Medical Society. And, I might add, I am mighty proud of it. Let me, in the minutes remaining, mention some of the ways in which the doctors of Illinois spent their time, money and experience for public welfare, aside from their personal contribution of good medical care.

First, it has attacked vigorously the problem of getting medical care to every part of the state, especially the smaller communities, so that no one anywhere is out of reach of a competent, well-trained physician. The physicians' placement service of the Illinois State Medical Society, the name by which we know this service, has served as a model for many other states. In our office at Monmouth, Dr. Harold M. Camp, our secretary for some thirty years, has organized two lists which are the basis for this service.

One is a list of the communities which want physicians, the other a list of physicians who want locations. It is his job — among his many — to match these two lists for the benefit of each.

That is not as simple as it sounds, for it is essential that the doctor like the community and find in it the things he wants for himself and his family, and equally essential that the community accept the doctor. Dr. Camp thus suggests to the community the methods it might adopt to make itself attractive to a doctor and to the doctor the things he might do to adapt himself to his new environment. It is an important service, for it is futile to talk of good health care unless there are competent medical men to provide it, and we are especially gratified to report that, through his efforts, more than a hundred doctors have been provided for Illinois communities which had none in the last two years.

But, to get doctors to communities, you must have doctors, and the Illinois State Medical Society has likewise gone one step further by setting up a mechanism to finance the expensive medical education that will make more doctors available for rural communities. In co-operation with the Illinois Agricultural Association, representing the alert and up-to-date farmers of Illinois, the Society has created a fund of more than \$100,000, half of which is loaned by each organization. The money is parcelled out in loans up to \$5,000 each to worthy medical students who will agree in return to establish themselves in practice in the rural communities of the state. We are also proud to report that there are now some fifty students in various medical schools under this arrangement, each of whom will some day increase the number of doctors in rural communities of Illinois. Half a dozen or more would be already so established except that the armed forces have taken them from us for two years. This service likewise has become a model for many other states.

Another statewide service is our Committee On Medical Service and Public Relations, which is charged with responsibility for bringing the physicians as a group and the general public closer together in mutual understanding. The program here is thereby to eliminate by education the misconceptions about medicine existing

in the minds of many and on the other hand to call to the attention of the medical men methods of eliminating those aspects of medical practice which the public finds objectionable. Thus the public relations committee urges medical societies to establish mediation or grievance committees, emergency call services, training programs for medical assistants, ethical relations committees to handle the occasional offender, and other activities that make for better public relations.

Likewise it is charged with another responsibility important to the public — that of organizing the fight against socialized medicine, or government control of medicine — the fight, in other words, to keep medicine free. It may not be generally realized that this is one of medicine's finest services to the American public, for government-controlled, bureaucratic medicine can never be of the quality the American public has learned to expect from its free medical profession.

My time is running short and I will only mention several other important services organized medicine provides — health education through radio, television and press releases explaining good health care and practices, a legislative observer alert to cry warning against bad bills and to seek support for good bills affecting the health of the people of Illinois, the many

advisory committees on cancer, maternal welfare, heart disease, public aid, and other key issues; its Illinois Medical Journal, one of the best in the country, its aid to medical education generally to keep the government out of control of medical schools — and many others.

I should say also that, while I have talked here of the work of the Illinois State Medical Society, as the more familiar aspect of organized medicine to me, equally valuable and intensive efforts are being carried on at the country medical society level. I want to pay my highest compliments to the Henry County Medical Society and its officers, Dr. Schmidt, president, Dr. Binder, secretary, and Dr. C. Paul White, a recent president of the state society, for its work in this community. If time permitted, I could elaborate on this theme, as well as on the work of the American Medical Association at the national level.

That, my friends, is a brief outline of organized medicine and what it means to the American public, in this instance, the public of the great state of Illinois. In closing may I reiterate my appreciation of the privilege the Henry County Medical Society has bestowed on me of appearing here and speaking to you and thus renewing my faith in American medicine and the American public.

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## SCHOOL EXPENSES

On the average, the medical student spends \$1,500 a year in addition to tuition and fees. Books, supplies and equipment cost \$150 and living expenses amount to \$1,350. Tuition at the schools studied has a median value of \$800, making the total cost for a student about \$2,300 a year, or \$9,200 for the student to complete his

four years of medical training. This study does not cover the cost of premedical training, internship and residency training, or the cost to the young physician of setting himself up in practice. *Sarah Counts, Ph.D., and John M. Stalnaker, Director of Studies for the Association of American Medical Colleges, The Cost of Attending Medical School. J. M. Education, February 1954.*

# Women Physicians Graduating from University of Illinois

Carol L. Birch, M.D., Mr. Maurice J. Galbraith and George R. Moon,  
Chicago

Early in the fall of 1951, a brief questionnaire was prepared and mailed to all of the women who graduated from the College of Medicine of the University of Illinois during the period from 1921-1945 inclusive, and who were listed in the new A.M.A. directory. During this twenty-five year period 151 women graduated.

The purpose was to learn how active these graduates are in the practice of medicine and what phases of medical practice have attracted them.

Of the 151 women who graduated in this twenty-five year period, ten are dead, and 141 are believed to be living. Of the one-hundred forty-one questionnaires which were mailed, 8 were returned by the post office and 117 were returned completed. Thus, of the 133 which apparently reached their destination, 88 per cent were completed and returned. The 24 graduates who were not reached, or did not reply, were omitted from the statistical computations since it seemed reasonable to assume that at least as many of them were in medical work as of those who replied.

Of the 117 living women graduates from this twenty-five year period who completed the questionnaire, all but 12, or 90%, are now making direct use of their medical education. However, 2 of the 12 who reported not practicing now stated that they definitely planned to resume practice at some time in the future and one other said she might do so.

Every one of the 12 reporting as not in practice is married and has children. In each case the chief reason given for not practicing is the care and raising of these children. It is possible that several of them may resume practice when the children are older, since none of the 12 can be considered very aged. The oldest graduated in 1931. Health was given as a second factor in two of the 12 cases. It appears that

the women of this group did not retire from the field of medicine as they grew older, but only as their financial status became secure as a result of successful marriage and their children needed them.

Most of the 12 reported that they had spent several years in private practice. One who married while a student practiced only one year. Three practiced for five years, four for six years, one for eight years, two for ten years, and one for thirteen years. In other words, 11 of the 12 practiced five years or more. Only one of the 117 graduates failed to practice for five years.

Seventy-eight of the 117 who replied are, or have been married, and 56 have children. Forty-four of the 117 continued to practice while raising families. Thirty-five married physicians. Fifteen married men in some type of business, seven teachers who were not physicians, five lawyers, three engineers and two dentists. Six reported being married, but did not mention their husbands' occupations, while the remainder married men in a variety of occupations or professions. It may be significant that all of the twelve who reported retirement from medical work were married and seven of them married physicians. This leaves 105 in medical practice.

In reply to a question concerning specialization in practice, the following information was secured. Thirty-six, or 33%, of the 105 in practice stated that they have board certification in some specialty, but many more reported that they were specializing in practice. The actual number working in each specialty field is indicated below:

Psychiatry 12 plus	Anesthesia	6
5 working in	Dermatology	5
mental hospitals	Ophthalmology	3
Ob. and Gyne 13	Surgery	2
Pediatrics 13	Pathology	1
Internal Med. 7	Roentgenology	1

In addition we find that eight are in Public Health work, five are practicing in mental hospitals, five are associated with universities doing

teaching or student health work, one is a medical officer in the U.S. Army, and one is a full-time hospital administrator.

This leaves twenty-two who are general practitioners. Of these, seventeen are in full-time practice in this country and three reported only part-time practice. Two sent their questionnaires from India where they are medical missionaries, apparently working about twenty-two out of twenty-four hours in the day.

It is interesting to note that out of 105 reporting active participation in medicine 37 or 35% have some type of university teaching appointment.

The extent of their migrations is not given but Their present location gives some idea of their travels. The following list of states show how many are now located in each:

Illinois	46	Arkansas	1
California	13	Connecticut	1
Michigan	10	Iowa	1
New York	6	Kentucky	1
Minnesota	4	Maryland	1
Oregon	3	Nebraska	1
Pennsylvania	3	New Hampshire	1
Wisconsin	3	North Carolina	1

Indiana	2	Utah	1
Tennessee	2	U.S. Army	
Arizona	1	Washington, D.C.	1
Two are in India			

Some comparable data are available on men who graduated from the college during the same period. Questionnaires were sent to the men who graduated in June of the years 1928, 1933 and 1935. Only 198 replies were received from the 368 sent but — 54% as compared with the 117 received from the 141 sent to the women. Four, or 2% of the men who replied have left the practice of medicine. Fifty-six percent of these men are specializing in their practice, compared with some 83% of the women. However, 40% of the male group, as compared with 33% of the women, report Board certificates.

Thirty-one percent of the men, compared with 35% of the women hold teaching appointments. More of the men have settled in their home state: 62% of the men are practicing in Illinois as compared with only 44% of the women.

Available data seem to indicate that these women medics are practicing a lot of medicine and compare very favorably statistic-wise with a comparable group of men.

CALORIES UNLIMITED!

From 1809 until 1816, "The Society for Promoting Vaccination" was active in Philadelphia in an effort to convince the residents that they should be vaccinated against smallpox. Has the time come for a new group, "The Society for the Prevention of Obesity?" It may even be foreseen that any member in good standing of that society would come day or night to hold the hand and support the wavering will of one who wrestles with an intolerable craving for unneeded food. *Lemuel C. McGee, M.D., Hiatus in Preventive Medicine. Indust. Med., Jan. 1954.*

YOUR HORMONES ARE SHOWING

Males are likely to be aroused by a wide variety of psychological sex stimuli, females by only a few. Physiologically also, female functioning involves a distinctly different and characteristically lower pattern. Production of the hormone group labelled 17-ketosteroids in males exceeds that of females from adolescence onward. Male levels rise above 15 milligrams per day during the 20's, declining to 10 milligrams at age 50. Peak production by females also is attained in the 20's but rises to a level of only 10 milligrams, thereafter declining to 6 or 7 by age 35. *A. H. Hobbs and W. M. Kephart, Professor Kinsey: His facts and fantasy. Am. J. Psychiat., Feb. 1954.*

# CASE RECORDS OF THE COOK COUNTY HOSPITAL

KARL MEYER, LEO M. ZIMMERMAN, DEPT. EDITORS

## Interstitial Mediastinal and Subcutaneous Emphysema in Acute Schizophrenia

R. J. Gardner, M.D., V. G. Urse, M.D., and B. Skorodin, M.D.  
Chicago

Interstitial mediastinal and subcutaneous emphysema has been reported as a complication of asthma<sup>1,2</sup> many respiratory diseases<sup>3</sup>, trauma<sup>4</sup> and labor<sup>5,6</sup>. Pneumothorax may or may not accompany the emphysema.

Gordon<sup>5</sup> found that as a complication of labor, emphysema was most common in young primiparae. Dystocia and prolonged labor were common findings and the bearing-down efforts during labor seemed to occupy a definite place in the etiology.

The following is submitted as a report of a case of interstitial and subcutaneous emphysema occurring in the course of an acute schizophrenic psychosis, during which the patient for several days in succession engaged in intermittent bearing-down movements similar to those exercised during labor.

It is reasonable to assume that during the acute stage of the psychosis the patient's phantasies revolved around child bearing, labor and delivery and that the acting out of her phantasies through bearing-down movements resulted in the unique complication.

Mrs. K. L., a 25-year-old white married female was admitted to the Cook County Psychopathic Hospital on December 16, 1951 with the information that acute mental symptoms appeared a week previously. She cried, prayed and stared into space. She also developed attacks of breath-holding.

She had one child — 4 lbs. 15 Oz — born prematurely 4½ months before. Labor was short and relatively easy and the delivery spontaneous.

There was no history of trauma, ingestion of foreign bodies or of noxious agents prior to her admission to the Hospital.

Examination upon admission revealed that patient was an undernourished white young female who was completely withdrawn to the point of not responding at all to questioning or saying anything on her own.

The body musculature was in a state of waxy flexibility. The temperature was 101 F. rectally, pulse rate — 84 and the blood pressure — 116 systolic, 78 diastolic. She was observed holding her breath at intervals at deep inspira-

tion and bearing down as if in labor. The superficial veins of the face, neck, chest and abdomen became distended with each such effort. A petechial rash was present at the side of the neck. Upon palpation, crepitus was noted over the face, neck and anterior chest wall extending on the right from the level of the eyes to the costal margin and on the left from the zygoma to the nipple line. There was no edema or discoloration of the area.

Ear, nose and throat examination disclosed a moderately injected pharynx with a moderate amount of white exudate. The findings of the lungs, heart and abdomen were within normal limits. Pelvic examination revealed a cervical erosion and a scanty white exudate in the vagina originating in the cervical os. The rest of the physical examination was negative. No evidence of trauma was found.

Laboratory findings were as follows: Red blood count — 5,520,000. Whites — 8,550. Urinalysis and serology of the blood and of the spinal fluid were negative. A cervical smear showed evidence of a non-specific mixed infection.

X-rays of the chest revealed no evidence of rib fracture, foreign bodies or pneumothorax. A small amount of air was seen on the left border of the mediastinum. A flat plate of the abdomen was negative.

The diagnosis was made of catatonic schizophrenia with interstitial mediastinal and subcutaneous emphysema.

Patient continued with her bearing-down movements every 10-15 minutes during her first day in the hospital. Then the catatonic stupor began to lift gradually and she made feeble efforts to communicate. However, her verbal productivity during the time she remained in the Hospital was never adequate, so that attempts to establish contact with her remained unsuccessful. It was consequently impossible to get directly at her mental contents, preoccupations, ruminations and phantasies. She did complain of substernal pain aggravated upon deep inspiration. As the catatonic state lifted, the bearing-down movements and breath-holding attacks gradually diminished and on

the third day of her hospitalization they completely stopped. On the same day the rash disappeared and the temperature became normal. At the same time, the emphysema began to subside and it disappeared completely by the end of her week's stay in the Hospital, following which she was transferred to the Illinois Neuropsychiatric Institute for further treatment.

#### DISCUSSION

The similarity between the emphysema in our patient and that occurring as a complication of labor is apparent. It is believed that the bearing-down efforts produced a valsalva-like phenomenon with diffusion of air from the perivascular and peribronchial interstitial tissues into the mediastinum and thence along the trachea into subcutaneous tissues of the neck, face and anterior chest. As long as this outlet is provided, the right auricle and great vessels in the mediastinum are put under no tension and no specific intervention is necessary. The subcutaneous emphysema is in itself harmless and disappears rapidly.

#### SUMMARY

A case of acute catatonic schizophrenia complicated by interstitial and subcutaneous emphysema is described. The emphysema resulted from intermittent forced expiration against a closed glottis which took place during bearing-down movements.

A similarity is apparent between this case and cases of emphysema occurring as a complication of labor. The logical inference is that patient was acting out her intense phantasies about childbirth.

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# PATHOLOGY CONFERENCES

EDWIN F. HIRSCH, DEPARTMENT EDITOR



## Fracture of the Anterior Cranial Fossa with Chronic Meningitis and Frontal Lobe Abscesses of the Brain; Infundibular Craniopharyngioma of the Brain

Edwin F. Hirsch, M.D.  
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Chicago

### **FRACTURE OF THE ANTERIOR CRANIAL FOSSA WITH CHRONIC MENINGITIS AND FRONTAL LOBE ABSCESSSES OF THE BRAIN**

A youth aged 13 years entered St. Luke's Hospital in the care of Doctor Eric Oldberg on January 12, 1953. In August of 1950 he had a fracture of the base of the cranium, was unconscious for two weeks, had a loss of vision of his left eye for six weeks, then recovered completely and seemed well until December 14, 1952 when he began to have frontal headaches. On December 21, 1952 he had a convulsion involving the right facial, shoulder and arm muscles, associated with fever. He responded to antibiotic therapy. After this he had several convulsive seizures involving both sides of the body and associated with fever. On January 10, 1953 he had another bifrontal headache followed by a convulsion with twitching of the right face and arm.

When admitted to the hospital he was physi-

cally developed for his age. He had a persistent tic of the right angle of his mouth, the head was rotated to the left with spasm of the left sternocleidomastoid muscle and the left hand was held up and under the occiput. The rectal temperature was 99°F., the pulse 90 and the respirations 24 per minute. The blood pressure was 140/60 mms. Hg. The blood had 5,000,000 red blood cells and 10,650 leukocytes per cmm. and 13 gms. percent hemoglobin.

The patient was confined to bed and manifested varying degrees of irritability. He received penicillin, his irritability increased, nuchal rigidity was marked and the turbid spinal fluid had a pressure of 420 mms. water and a large granular sediment. Kernig's sign was positive and there was evidence of right sixth nerve paralysis. No organisms grew in cultures of the spinal fluid. He received doses of several antibiotics. The spinal fluid on January 24, 1953 contained 2,033 red blood cells, 1,623 polynuclear leukocytes and 102 lymphocytes per

c.mm. He was lethargic, had irregular pupils that did not react to light; the right pupil was smaller than the left. There were a complete right sixth nerve paralysis, nystagmus on lateral gaze and impaired upward movement of the eyes bilaterally. The discs were flat, deep reflexes were brisk, and his speech was slow. The impression was a chronic pyogenic meningitis with small activated foci of infection pocketed in the arachnoid. On February 22, 1953 a cysternal puncture released 2 cc. of purulent fluid streaked with shreds.

The boy's condition worsened, he became incontinent, his leukocytes rose to 15,700 per c.mm. He was given oxygen but died on February 14, 1953.

The main portions of the anatomic diagnosis of the necropsy (complete) are:

Old transverse fracture of the anterior portion of the right orbital plate of the frontal bone;

Chronic purulent right frontal sinusitis of the cranium;

Chronic purulent basilar meningitis;

Large abscess of each frontal lobe of the brain;  
Etc.

The superficial and deep scalp tissues had no recent injuries. The deep scalp tissues were edematous. The dura was adherent to the base of the cranium in the anterior fossa. The crista galli was deviated to the left, and in front of this and to the right was an opening 1.2 by 1

cms. into the right frontal sinus. The dura was densely adherent here and the sinus contained a purulent exudate. Near the center of the right orbital plate of the frontal bone was a granular callus 1.5 by 1 cms. and elevated about 3 mms. The cerebrospinal fluid was stained with blood, and culturally contained staphylococcus aureus, diphtheroids and an unidentified gram-negative bacillus. The leptomeninges were thin except over the entire base of the brain and here they were thickened by gray-yellow exudates. The tissues at the base of the right frontal lobe were discolored yellow-brown, were necrotic and the brain opposite this focus was fluctuant. The convolutions were flattened and the sulci correspondingly narrowed. The brain weighed 2010 gms. The left frontal, both ethmoid, the sphenoid and both maxillary sinuses had no changes, so also both middle ears.

The inferior surface of the frontal lobes of the formalin hardened brain from the tip to the anterior edge of the temporal lobe had a region of yellow-gray 10.5 by 6.5 cms. On each frontal lobe here was a soft place 5 by 4 cms. on the right side with a necrotic center 2.5 by 2 cms. In the anterior portion of each lobe was an abscess, the one in the left 5.5 cms. long and 3.5 cms. in dia., the one in the right 2.5 cms. in dia. Both were filled with thick mucopurulent exudates (Figure 1). The left lateral ventricle was dilated and contained a quantity of thick green-yellow exudates. The right lateral ventricle had

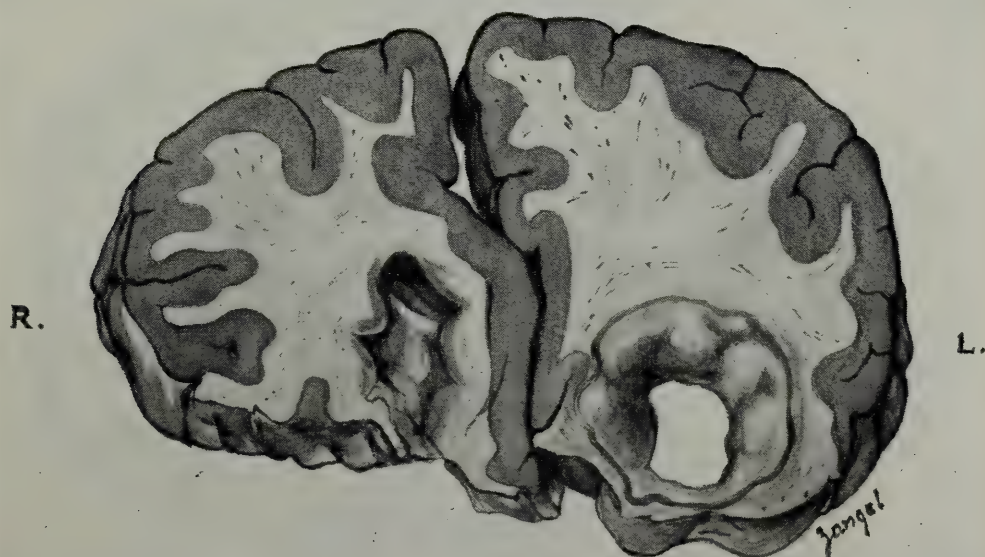


Figure 1. Sketch illustrating the abscesses in the anterior portion of each frontal lobe of the brain.

a small amount. At the level of the optic chiasma, just below the left lateral ventricle was a small abscess 0.8 cm. in dia. ruptured into the ventricle. The third and fourth ventricles of the brain also contained a quantity of purulent exudate and the lining of the fourth was necrotic. The viscera of the trunk had no significant changes or unusual tissues.

#### COMMENT

The history and necropsy findings illustrate a late complication of a fracture of the base of the cranium in which a chronic osteomyelitis develops from a sinus or otherwise. The meninges become involved and finally one or more abscesses of the brain develop. The long time during which these sequences of infection unfold can mislead the clinician in his evaluation of the patient's illness. In fact, the history of an injury could be dismissed as insignificant. Smoldering infections of the cranial bones are a potential focus for a secondary abscess of the brain.

### INFUNDIBULAR CRANIOPHARYNGIOMA OF THE BRAIN

This adult white woman aged 49 years entered St. Luke's Hospital in the care of Doctor Eric Oldberg on April 15, 1953. In March 1941 the left kidney had been removed because of hydronephrosis and in 1942 and 1946 she had been in the hospital for acute bronchitis. She came to the hospital again in June of 1947 because of chronic severe supraorbital and suboccipital

headaches, fatigue and weakness. About six weeks before entering the hospital she began to deteriorate mentally and had definite personality changes. An encephalogram on July 9, 1947 revealed no changes, but a tap of the left temporal region on July 15, 1947 disclosed a large subfrontal cyst. This was aspirated and the presence of a craniopharyngioma was considered. After ten days she was discharged in good condition and remained well until November, 1947. Another aspiration of the left frontal lobe was done in February 1948. She again entered the hospital in September 1948 with severe headaches and markedly decreased vision. At this time through a left frontal trepanation a craniopharyngeal cyst in the intraventricular and chiasmal regions was drained and a partial extirpation of its capsule was done. These tissues had the structure of a craniopharyngioma. Recurrence of symptoms forced the patient to return to the hospital in December 1948, in May and in August of 1952, and finally on April 17, 1953 she was admitted in a coma. She had been semicomatose for several weeks and had had two convulsions on the day of admission. Her temperature was 101.2°F., the pulse was 100 and the respirations were 22 per minute. She remained in deep coma, failed to respond to painful stimuli; the light and corneal reflexes were absent. The day following admission the spinal fluid pressure was 480 mms. of water. Her con-

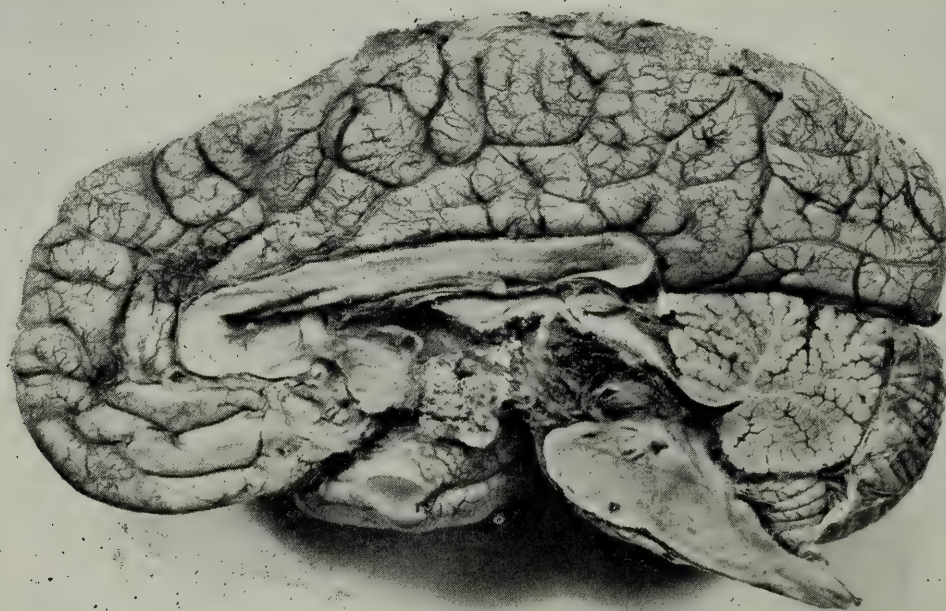


Figure 2. Photograph of the formaldehyde fixed brain, hemisected sagittally and illustrating the craniopharyngioma tissues on the right side of the midline.



**Figure 3.** Photograph of the formaldehyde fixed brain, hemisected sagittally and illustrating the craniopharyngioma tissues on the left side of the mid-line.

dition deteriorated, the temperature rose to 107° F. and she died in coma on April 17, 1953.

The main portions of the anatomic diagnosis of the necropsy (head only) are:

Craniopharyngioma of the infundibulum of the brain;

Old left surgical craniotomy;

Etc.

The brain weighed about 1170 gms. The accessory sinuses of the cranium had no changes except small amounts of mucinous secretion. The cerebral and cerebellum hemispheres were symmetrical. In the lateral portion of the left frontal lobe 3 cms. posterior to the tip was an old surgical defect 2 cms. in dia. from which a clear yellow fluid exuded. In the space between the optic chiasma and the pons was a gray tissue with multiple cysts ranging to 2 cms. dia. The brain was hemisected sagittally and in the region of the infundibulum were multiple small cysts ranging to 5 mms. dia. in gray tissues also granular and with foci of calcification (Figures 2 and 3). This mass was 1.3 by 1.1 by 0.7 cms. and in front of it were two other cysts each 1.5 cms. in dia. At the level of the cerebral pedun-

cles, above the pons and in front of the fourth ventricle was a mass of soft dark red tissue, 2 cms. in its greatest dia. The craniopharyngioma tissues histologically were mainly masses of squamous epithelial cells with considerable hornification, and frequent epithelial pearls. The scanty stroma had foci of foreign body granulation tissues with giant cells. These tissues extended posteriorly to the pons.

#### COMMENT

Craniopharyngiomas arise from squamous epithelial rests of Rathke's pouch. The growth at first is solid but later becomes cystic. Histologically the tumors contain squamous cells in masses or covering papillary stalks, or the tissues have the structure of an ameloblastoma, that is, embryonal enamel organ cells. The necrosis or liquefaction of cells leads to cyst-like structures that contain fluids with desquamated epithelial cells, cholesterol crystals, blood or blood pigment and exudates. Calcification and even ossification may occur. The growth invades and destroys the hypothalamus, fills the third ventricle and causes internal hydrocephalus. Roentgen films usually disclose significant suprasellar shadows.

## EDITORIALS



### A "BRAVE NEW SEXUAL SOCIETY"

For those who wish to read one of the few criticisms of Kinsey's reports on sexual behavior, we recommend an article by A. H. Hobbs and W. M. Kephart, in the February issue of the *American Journal of Psychiatry*. These sociologists point out that in the second volume, "among the 5,940 white, non-prison females who were willing to describe their sexual activities in minute detail for Professor Kinsey the 75 per cent who had gone to college included a severely disproportionate 19 per cent with graduate education. Only 3 per cent failed to attend high school. Females of Jewish faith contributed almost 30 per cent of the interviews, while only 12 per cent were contributed by Catholics. Only one third of those interviewed were devoutly religious even according to the moderate and purely quantitative requirements for inclusion in this group. Practically all came from urban, white-collar, or professional families. Twenty-two per cent of those over 30 were still single, and of those over 30 who had married, 40 per cent were either widowed, separated, or divorced. No data are presented to indicate the number of children born to these females."

Another criticism stemmed from Kinsey's use of the accumulative incidence technic. In this method, each case is treated as if it were an additional case falling within each previous age group. A man who was interviewed when 45

years of age, provides statistical information for each group previous to that age. He might be married, but what he did prior to marriage is included with the single group. As a result, the critics remark that, "most people were infantile when they were infants, childish when they were children, and adolescent when they were in their 'teens, and such a technic would demonstrate these facts with reasonable accuracy. It could be used to demonstrate that 100 per cent of the population is 'selfish' (has engaged in selfish behavior) but it would also show that 100 per cent of the population is 'unselfish'."

Hobbs and Kephart agree that the collection and processing of over 11,000 records is a tremendous fact-finding and reporting task, but they are disappointed over the social and moral interpretations of these facts. These men point out that Kinsey's study has resulted in a brave new society of sexual behavior in which the forms now considered perverted will be somewhat "more normal" to society in the future. They cite as an example the children who had been molested by sex perverts. The youngsters were emotionally upset but the "new society" feels that they were no more perturbed than had they been scared by a spider. Furthermore, their parents probably were responsible for more emotional damage than the pervert, by creating a fuss and demanding police investigations. Does this mean that the actions of those adult mo-

lesters are justified and no longer condemned? Does it mean that the child benefits by the experience just because it contributed to his socio-sexual development?

"From the mists of fantasy there now emerges the brave new sexual society of Professor Kinsey. Many would obtain more sexual pleasure in this new society than they do now, and other benefits would accrue to some types of people. Single males would, as a group, probably derive the greatest benefit, and married males would appreciably increase their extramarital affairs. Persuasive evidence from the volume on females indicates that with premartial sexual relations condoned, if not encouraged, a smaller percentage of wives would be frigid. Homosexuals would no longer fear arrest and, with removal of social stigma attaching to their practices, they would be freed of guilt feelings. Adult molesters of children could sleep the sleep of the just, proud that their activities may have contributed favorably to the later sociosexual development of the child."

The reviewers believe that the facts lend little support to the fantasy. "The fantasy of a brave new sexual society in which females respond in the same manner and the same degree as males, may be reversed upon further homeopathic administering of the 'conditioning' remedy. Thus far the treatment has resulted in at best minor relief while the side-effects erupt in disturbing fashion. An open mind demands admission of the possibility that the fantasy can become reality. In appreciable measure it is becoming a reality. Who, but a short time ago, would have dreamed that cigarette-smoking, bar-hopping, pants-wearing females would operate streetcars and taxis, weld steel, and serve in the armed forces? Perhaps little girls can be 'conditioned' toward erotic responsiveness and sexual dalliance instead of homemaking, child bearing and rearing, premarital chastity, and marital fidelity. Perhaps the minor gains of somewhat decreased marital frigidity compensate for the increases in premarital immorality, in adultery, and in the decline in marital sexual performance. On the other hand the admittedly somewhat unrealistic ideal which exalts females as being endowed with qualities particularly qualifying them for a role as guardians of the sexual mores may have some value." What next?

## **SALK VACCINE TENTATIVELY APPROVED FOR ILLINOIS**

Dr. Roland R. Cross, director of the Illinois Department of Public Health, has approved a recommendation of the Illinois Poliomyelitis Technical Advisory Committee that tentative approval be given proposed controlled field studies with the Salk polio vaccine in Illinois and has so notified the National Foundation for Infantile Paralysis.

Dr. Cross gave his conditional approval of the studies in a letter to Dr. Hart E. Van Riper, medical director of the National Foundation.

The committee, which is advisory to the state health department, met in Chicago Friday night, March 19. Its recommendation follows:

"It is the opinion of the committee, that from the material now available, the vaccine proposed for use is safe up to the present time, and that the proposed control study under the direction of Dr. Thomas Francis, Jr. is an extremely important one, and there is a reasonable chance that the material will be effective in immunizing. It is recommended, therefore, that a tentative approval be given so that planning may proceed. Such approval should stipulate that evidence from clinical trials prior to those in Illinois should continue to demonstrate safety and effective antibody response. Should such trials show either of these to be untrue, the study should not be further pursued at that time."

Counties which will be given opportunity to participate — probably three or four — will be chosen after consultation between the state health department, the National Foundation and the county medical societies and county health departments concerned, Dr. Cross said.

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## **THE SECRETARIES' CONFERENCE**

On Sunday, April 4, 1954, the Secretaries' Conference was held at the Hotel Leland, in Springfield. The conference was arranged for officers of component and branch societies, and any member of the State Society was privileged to attend it, which information was given to the county society secretaries before the meeting.

The program was arranged by the officers of the Secretaries' Conference, consisting of Maurice M. Hoeltgen, Chairman, Lee N. Hamm, Vice Chairman and William DeHollender,

Secretary. The first speaker was C. Joseph Stetler, Secretary of the A.M.A. National Emergency Medical Service, who talked on National Legislation at the County Level. Mr. Stetler discussed the many legislative problems confronting the medical profession, and gave his evaluation of each of them. A question and answer period followed the talk as was the case with the other presentations.

Robert E. Heerens, Public Relations Chairman of the Winnebago County Society, Rockford, told an interesting story on How Secretaries can put P.R. to Work. This subject aroused considerable discussion by several officers of county societies, and others. Another well received presentation, was that of Mr. J. Paul Revenaugh, Senior Partner, Professional Business Management, Chicago, who talked on the subject "How Efficient is Your Office"?

There was a panel discussion on the subject "What are Your Problems, Secretaries?", with panelists representing the A.M.A., State Medical Society, and the Chicago Medical Society as the largest component society, and a small but efficiently functioning smaller county society. Following the introductory statements from each member of the group, the time was spent on a question and answer period.

The State Medical Society was host at the luncheon attended by approximately 130 members and members of the Woman's Auxiliary. The afternoon was devoted to the presentation of nine playlets presented by the Springfield Guild, each portraying a practical problem faced by county society secretaries, and physicians in general. Following each playlet, the question was asked "what would you do?", and a number of physicians endeavored to give the correct answer.

Following the presentations, officers were selected for the next annual Secretaries' Conference for 1955, — Chairman, Lee N. Hamm, Lincoln, Vice Chairman, Wm. DeHollander, Springfield, and the Secretary, is the incoming Secretary of the Chicago Medical Society. The group voted to request the House of Delegates and the Council to schedule the Conference separate from the annual meeting, and preferably at some downstate location.

Exhibit material was displayed throughout the

day, showing the services available at the State Society Secretary's office for component societies, functions and services of the Physicians' Placement Service, and copies of a number of brochures available for societies and individual members. Copies of bulletins issued by a number of component societies, and other material was also available.

Copies of the booklet "The Public Relations of County Medical Societies; Outline of a Program," developed by Mr. James C. Leary, P.R. Director for the State Medical Society were available for the members present.

There were approximately 100 physicians present, representing some 45 medical societies and it was the general opinion of those present that a full day each year should be devoted to discussions on the many problems of county medical society officers. Dr. Jacob E. Reisch, Councilor for the 5th Councilor District, and a resident of Springfield, assisted the officers of the Conference in arranging the program and having adequate facilities available.

The records of this Society show that on two previous occasions, prior to World War II, similar one day conferences were held in Peoria and in Springfield, and it seems quite probable from the interest displayed at this 1954 Conference, that arrangements will be made to hold an Annual Secretaries' Conference apart from the Annual Meeting.

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## **JAMES BRYAN HERRICK, 1861-1954**

James B. Herrick, a lifelong resident of Illinois, died at Presbyterian Hospital, Chicago, on March 7, 1954. His early education was received at the Oak Park High School, the Rock River Seminary at Mt. Morris, then at the University of Michigan where he graduated in 1882. After teaching a short time in the Central High School in Peoria, he entered Rush Medical College, graduating in 1888. Soon after completing his internship at the Cook County Hospital, Doctor Herrick joined the staff at Rush, where he remained until he reached the age of retirement.

Doctor Herrick was professor of Medicine at Rush from 1900 until 1927, then was designated as Professor Emeritus of Medicine at his alma mater. He was a member of the staff of the Presbyterian Hospital from 1890 and for a

number of years was president of the medical board. For 34 years he was attending physician at this hospital, and in 1924 was made consultant.

In 1912 Doctor Herrick became the first physician to describe and diagnose coronary thrombosis; in 1918, with the aid of the first electrocardiograph in Chicago, he was able to confirm the diagnosis. For many years Doctor Herrick insisted that he was general practitioner, but after his exhaustive studies on the cause and nature of coronary disturbances, he was designated as a cardiologist.

A member of many scientific societies and a specialist certified by the American Board of Internal Medicine, Doctor Herrick served as president of the Society of Medical History of Chicago, the American Association for the History of Medicine, the Association of American Physicians, the American Heart Association and the Chicago Institute of Medicine. He was one of the founders of the American Heart Association, and was interested in this and the many other organizations with which he was associated, until his death.

In 1939 the American Medical Association presented its Distinguished Service Medal to Doctor Herrick for his work on coronary thrombosis. He was a member of the Judicial Council of the A.M.A. from 1928 until 1934. In 1935 the American College of Physicians conferred upon him the title "Master", the first time this award had been presented in eleven years.

In 1949 Doctor Herrick published his biography entitled, "Memories of Eighty Years". He was the author of several other books, and he had many papers published in medical journals throughout the nation. One of his most notable contributions to medical literature was the article published in the Journal of the American Medical Association on December 7, 1912 — "Clinical Features of Sudden Obstruction of the Coronary Arteries". In 1910 Doctor Herrick first described sickle cell anemia as a distinct clinical entity.

Doctor Herrick for many years was very active in the Chicago Medical Society and the Illinois State Medical Society, which presented him his Fifty Year Club Certificate and lapel emblem upon the completion of fifty years of practice. Over a period of years, Doctor Herrick was given

honorary degrees by the University of Michigan, the University of Chicago and Northwestern University.

Thousands of physicians in Illinois and throughout this nation knew and respected Doctor Herrick as a teacher, a clinician and as a friend. He retained his interest in medicine and in medical progress, and in his professional associates until his death.

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## THE SKIN IN BELLES-LETTRES

Many scientific observations lie hidden in the writings of famous poets, essayists, novelists, and dramatists. From time to time we find a physician with the time and inclination to unearth this material. D. E. H. Cleveland, of Vancouver, confines his efforts along this line to dermatological comments and reported a few of his gems in the August issue of the Canadian Medical Association Journal.

Lord Chesterfield disposed of the cosmetic subject with the remark: "Women, who unfortunately have natural bad complexions, lay on good ones." He also commented, "penny plain, twopence coloured." Austin Dobson produced the following with a hint perhaps that he recognized the menopause:

"The ladies of St. James.  
They're painted to the eyes:  
Their white it stays for ever,  
Their red it never dies;  
But Phyllida, my Phyllida!  
Her colour comes and goes;  
It trembles like a lily;  
It wavers to a rose."

Kipling's verse went as follows:

"The blush that flies at seventeen,  
Is fixed at forty-nine."

Tennyson was more realistic when he said:

"Every face, however full,  
Padded round with flesh and fat,  
Is but modell'd on a skull."

The beard also occasioned no little concern among men of letters. This epigram of Kipling's is perhaps the most famous! "Being kissed by a man who didn't wax his moustache was like eating an egg without salt." This witticism became popular when military regulations forbade soldiers from shaving the upper lip.

Byron regarded shaving as a nuisance:  
"men for their sins

Having shaving too entail'd upon their chins,  
A daily plague, which in the aggregate  
May average on the whole with parturition."

One of the most amusing observations on the skin was made by Jonathan Swift in "Gulliver's Travels." He explained that when the fair skins of English women are seen through a magnifying glass, "the smoothest and whitest skins look rough, and coarse, and ill-coloured." It was for this reason that the skin of giants was described as nauseous, and that of the diminutive people of Lilliput as "the fairest in the world." One of Swift's most vivid descriptions is that of cancer on a Brobdingnagian breast. In referring to the holes, he stated, "in two or three of which I could easily have crept." Among the same people he removed a corn from a maid of honour which he "hollowed out into a cup which he had set with silver."

## WHO: WORLD HEALTH ORGANIZATION

Anfin Egdahl, M.D.  
Rockford

WHO came into existence April 7, 1948. This is a vital part of the United Nations and its slogan is: "Healthy Surroundings Make Healthy People". The primary objective of WHO is the attainment by all peoples of the highest possible level of health. It defines health as a state of complete physical, mental, and social well being and not merely the absence of disease or infirmity.

By the middle of the 19th century considerable progress had been made in medicine and leaders of the profession saw the need of a uniform nomenclature to designate different diseases and causes of death. In 1953 the first International Statistical Congress was held in Brussels to prepare a uniform nomenclature applicable to all countries. This led to the adoption of the International List of Causes of Death and also to an agreement to hold meetings every 10 years to revise the list. This era also saw the organization of the Red Cross. In 1862, Henry Dunnant, of Switzerland, published his *Souvenir de Solferino* describing the barbarities of war. This led to the International Conference of the Red Cross societies at Geneva

in 1863 and the signing of the Geneva Convention on August 22, 1864. Here fourteen countries pledged to regard the sick and wounded and the army medical and nursing staffs as neutrals on the battlefield. Another sign of the international spirit was the awarding of the Nobel prizes, not only for medicine but also for other contributions to human welfare and progress.

A few other international organizations were in existence before the organization of WHO. International d'Hygiene Publique was organized in Rome in 1907 to function as a center for the dissemination of public health information. It continued so to function, with offices in Paris up to the time of its absorption by WHO. UNRRA, organized in 1944 also was absorbed by WHO. Of special interest was the League of Nations Health Group organized shortly after World War I. Although the United States was not a member of the League of Nations the health group had the support of this country and much good was accomplished. Campaigns were carried on against typhus fever in Russia, Poland, Greece, Turkey, Italy, the Balkan States, Palestine, Syria and Persia. Studies also were carried out on tetanus diphtheria, and dysentery. Another useful function of the League of Nations Health Group was the training of health personnel, the exchange of epidemiological information, and the encouragement of visits between medical research groups in different countries. The narcotics evil also was investigated. A convention of a number of countries had been held in 1912 to study the subject and certain restrictions were recommended. Most of the countries of the world signed, including the United States. Although some good was accomplished the sources of supply of narcotics had not been as closely controlled as was desirable. Another meeting was held in 1924 in which the League of Nations Health Group took an active part. At this meeting drastic restrictions on the growth and manufacture of narcotics were passed with the understanding that these drugs were to be used only for medical and scientific purposes. The League of Nations Health Organization also interested itself in the care of prisoners of war. Among other recommendations was that these prisoners should have the service of skilled medical help when ill or wounded.

The League of Nations Health Organization was taken over by the Interim Organization of WHO in 1946; this included the bureau of Epidemiological Intelligence in Singapore with its Darling and Bernard funds.

An Interim Commission worked out details of WHO before it was fully organized in 1948. Among the details that had to be worked out were the budget, the headquarters and regional organizations, the relationship of WHO to the United Nations and nongovernmental organizations interested in health, and the transfer to WHO of the League of Nations Health Organization and the International Office of Public Health of Paris. Three million dollars were made available to the organization for two years. UNRRA also made available three million dollars for activities in countries in which UNRRA had been active. WHO also had taken over the Pan-Arab Sanitary Bureau with headquarters in Alexandria and the Pan American Sanitary Organization. It also seeks to collaborate with other nongovernmental organizations, such as the World Medical Association, the World Federation for Mental Health, and the International Union against tuberculosis, venereal diseases, and cancer. It has the co-operation of the International Council of Nurses.

The Commission recognized in planning its work that priority should be given to diseases of greatest importance to the greatest number of people in world involving millions of people annually. Emphasis is laid on developing healthy generations by the application of new methods in maternal and child hygiene. The diseases singled out on the above basis are malaria, tuberculosis, and venereal diseases.

WHO came into existence, April 7, 1948, by the acceptance of the constitution by 27 members of the United Nations. It is hoped that health workers of the world can co-operate effectively in planning and executing a program to promote the attainment by all people of the highest possible level of health. Associate membership was also established but these countries and organizations do not have the right to vote or serve on the executive committee unless later this privilege is given later. They may propose items for inclusion in the agenda of the assembly.

Malaria, now rare in this country still is of prime importance to the entire world. It attacks

about 300 million people annually, killing about 3 million each year. Most of these people are workers in agricultural areas but the impact is felt in nonmalarious areas through the deprivation of food. The debilitating effect of recurring malarial attacks causes a reduction in man power. Today this disease in a large measure can be controlled by the use of DDT. A good example of what can be done is shown by the results in Greece. Through the centuries one to three million out of 7.5 million people have been attacked by malaria every year. The disease has now been reduced to a minor problem by a few experts sent in by UNRRA and now maintained in Greece by WHO. A similar good result was obtained in Egypt by a few experts who taught the Egyptians what to do. The Food Agricultural Organization has recognized the significance of malaria and, in introducing modern agricultural methods, particularly where irrigation is employed it has sought the aid of WHO in preventing the mosquito pest with consequent danger of epidemics of malaria.

Tuberculosis is one of the great enemies of mankind. The death rate is always increased by calamities as in war and famines. Overcrowding, malnutrition and close association with active cases due to breakdown of control measures, leads to an enormous increase in the disease with marked rise in the death rate. The essence in controlling the incidence of tuberculosis is in finding active cases and putting them in a sanitarium with the idea not only of cure but also preventing them from infecting others. The rate of infection in the war areas of Europe, Asia, and Africa is very high as shown by X-ray examination and tuberculin surveys. The old tested methods of control must be carried out, with pasteurization of milk and proper surveillance of food and food handlers. BCG vaccination is being used on a large scale in Europe. Internationally the final conquest of tuberculosis is in the hands of the United Nations and its special agencies concerned with economic health. This disease can be suppressed by a planned attack. In Denmark the death rate is only 32 per 100,000 as contrasted with 200 to 300 per 100,000 in several other European countries. The plan calls for a campaign of education, the training of experts, not only in tuberculosis of man but also of cattle, in improved housing and

proper food supplies, and possibly in BCG vaccination.

Following wars there has been always a marked increase in venereal diseases over wide areas, due to shattered economic conditions and a breakdown in morals in so many of the people. Also in the countries not directly involved there is an increase in these diseases as a result of the situation in the involved countries. In parts of Africa 75 per cent of the population has syphilis. In the Scandinavian countries venereal diseases before the last war had been reduced to insignificance but following the war there was a marked upsurge; now again there is a marked reduction. We have now in penicillin an excellent remedy against both syphilis and gonorrhea. WHO plans to use this remedy on a large scale in countries when a campaign is needed. Long established control methods involving case findings, case tracing, mass blood testing, suppression of prostitution, and adequate treatment are measures that have been found effective in campaigns and other commissions of the United Nations will have to furnish aid, particularly those engaged in social work such as UNESCO.

In the USA marked decrease in deaths of mothers in childbirth and of children at birth has taken place. The deaths of babies fell from 58.1 in 1933 to 35.1 in 1945, and of mothers in confinement from 6.2 to 2.1 per thousand in the same period. There are places in the tropics where 20 to 30 per cent of children die in the first year and 50 per cent before the fifth year. Infectious diseases, parasites, and malnutrition are

in a large measure responsible for these deaths. Blindness is also an important problem to be considered by the WHO.

WHO will contribute greatly to solving these problems by focusing attention upon them, by extending aid to all of the world, and by fellowships in proper institutions. Provisions for instruction of personnel are available in various fields, as in public health, nursing, sanitary engineering, industrial and rural hygiene, public health education, mental health, nutrition, leprosy, influenza, poliomyelitis, cancer, and animal parasites.

The commission has entered into relation with some voluntary organizations like International Union Against Tuberculosis, the International Union Against Venereal Diseases, International Congress on Tropical Medicine and Malaria; The International Congress on Mental Health, and the International Congress on Microbiology.

Germs travel as fast as man does. The time needed to fly from India, Africa, South America to the United States has been cut from months and weeks to a few days or a few hours. Bubonic plague germs can go on board a plane with their victim in India and be in New York within several hours. It is of the utmost importance that a public health service keeps a watchful eye on all planes flying between foreign countries and parts in our country to prevent the introduction of epidemics. Planes are now fumigated not only to kill harmful organisms but also mosquitoes, flies and other insects.

# MEDICAL ECONOMICS

**The Medical Economics Committee. John R. Wolff, Chairman, Walter C. Bornemeier, Edward W. Cannady, Roland R. Cross, Jr., E. F. Dietrich, W. W. Fullerton, Edwin F. Hirsch, Frederic T. Jung, W. R. Malony, Caesar Portes, William Requarth, Frederick W. Slobe.**



## Our Good Neighbor Policy?

Buenos días amigos.

One of the most important attributes of today's successful senior attending physician is his knowledge of conversational Spanish and Portuguese. The book most widely read in Illinois hospitals is the Spanish-English Dictionary.

Since World War II the shortage of interns has become an established fact. The supply of interns does not come close to satisfying the demand. And with the projected increase in hospital beds compared to the very slow increase in potential interns this situation will be with us for a long time.

The American medical student now has his choice of hospitals. He no longer takes an examination for internship; he gives one. He chooses the large teaching center, or the institution providing a desired residency, or occasionally where the salary and the climate are nice.

This has left many open places for interns in practically all the private hospitals in Illinois. At first the hospital completed its intern quota by accepting European refugee applicants. This proved to be a successful venture. Those men understood our language, they had a good fundamental knowledge of medicine, and they were

mature thinking individuals with a program for the future. All eventually became citizens, and recognized physician members of their communities.

But news travels fast. And the opportunities in Illinois soon became well known to the graduates of Mexican, Cuban, Central and South American Universities. In our urge to obtain interns they were all accepted. And usually on very flimsy recommendations.

The first problem is the language barrier. This is not insurmountable. But the internship should not be started until the intern resident is well versed in the vernacular of Illinois. Otherwise the first several months are wasted.

However, the major problem is not the immediate role of the individual in his internship but the more important one of his eventual future.

The American medical student has a definite plan. Internship, armed forces service, and then general practice or residency training toward specialization.

But what about our Latin friends? Like Topsy, they just grow up. A few have planned

programs, but the majority seem merely to be serving time. They serve multiple internships, or various residences in an effort to stay in this country.

By all means America is the land of opportunity and freedom. We must continue to welcome these men. We must help them become good doctors, not poor ones.

To accomplish this we must accept the fact that our Latin students will continue to be with us and take constructive steps to fit them into the American plan? Is not this the responsi-

bility of our medical and hospital organizations?

Why not have a language examination for all foreign interns applicants; and at a national or regional level? Isn't it necessary to help arrange a suitable training regime at the state or local level so that each individual will be aided in his quest for an American future?

We are guilty of not ourselves meeting this problem. We should not leave everything to the State Board of Examiners, but should plan to help these young Americans so that they, in time, can help us.

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## EPISTAXIS DIGITORUM

As a rule, children rub and pick their noses because of allergy and an itching nose. Adults, on the other hand, and especially women, will wipe far up into the nasal vestibule beyond the mucocutaneous border and scrub the delicate nasal mucosa until it bleeds. Later it forms granulations and crusts, and a scar replaces the mucosa. Once these "nose-pickers" have achieved crusting, they have created something real to go up after and the condition perpetuates itself. This finger produced ulcer eventually made erodes through the septum and causes perforation. It is the established practice to cauterize the Kiesselbach plexus on the septum, which commonly bleeds from this type of nose-picking and wiping. It is thought that cauterizing effectively destroys the bleeding vessels and prevents further epistaxis. However, it is my belief that more often the cauterizing agent, whether chemical or electrical, simply makes the nose so terribly sore and tender, the chronic nose-picker leaves it alone long enough to heal spontaneously. The actual destruction of the blood vessel is irrelevant. *Richard T. Barton, M.D., Massive Nasal Bleeding. Postgrad. Med. Jan. 1954.*

## THE PSYCHE AND MENSTRUATION

Each patient with a menstrual disturbance thus far studied in the Gynecological-Psychiatric Unit has shown a definite emotional conflict. In the women with dysmenorrhea, the predominant conflict seems to lie in the sphere of accepting adult feminine responsibilities. It often is expressed in excessive drive toward independence and activity between periods and giving in to childish, dependent wishes during the menstrual period. In the woman with functional amenorrhea and oligomenorrhea, the sexual and reproductive roles of women's life are consciously unacceptable. The idea of femininity is rejected in favor of masculine behavior, or the idea of sex is associated with the sordid and forbidden. At the same time these patients have a deep wish to be normal women and mothers that does not reach their conscious awareness for various reasons. These two psychologic configurations are not sharply delineated but may merge into each other, as with the occasional patient with dysmenorrhea who has some menstrual irregularity or the patients with oligomenorrhea who have painful periods. *Doris Menzer, M.D., The Importance of the Psychologic Factor in Gynecology. New England J. Med. Sept. 24, 1953.*

# THE P.R. PAGE



## Annual P.R. Dinner

The annual public relations dinner, to be held Tuesday evening, May 18, in the Hotel Sherman during the 1954 annual meeting, will present Harrison C. Putman, M.D., of Peoria, chairman of the public relations committee of the Peoria County Medical Society, in an address describing the Peoria PR program.

The other speaker, as announced last month, will be Frank E. Wilson, M.D., of Washington, director of the Washington office of the American Medical Association, who will line out for PR chairmen and other county representatives the role they are expected to play in national legislative issues.

Percy E. Hopkins, M.D., of Chicago, chairman of the Committee on Medical Service and Public Relations of the Illinois State Medical Society, will be chairman. Members of the committee, including Harold M. Camp, M.D., of Monmouth, secretary, will be present.

Those attending will be free to ask all the questions they please. Plan to be there. It will break up in time for the hospitality hour to follow.

## Iowa Tests Members' Ideas

The Iowa State Medical Society recently sent out a questionnaire asking members to indicate their views on the stand taken by itself and the American Medical Association on legislative

problems. Five test questions covered the VA controversy, the Keogh-Jenkins bills to permit delayed taxation on retirement funds, extension of social security, the Bricker amendment and more liberal deductions for income tax purposes on medical expenses.

The society got back 814 replies, which were overwhelmingly in favor — 83 to 95 per cent — of the stands taken by organized medicine on each of these issues. It was a satisfactory experience for both officers and members — officers because they were happy to feel the support of the organization and the members because they were glad to get a chance to express themselves.

## The Fight is Always Against Socialism

Another aspect of Socialist propaganda which crops up more and more in the current literature is the Socialists' own comparison of themselves with the Abolitionists of a century ago. The implication, of course, is that, just as the Abolitionists finally prevailed and wiped out slavery, so the Socialists will finally prevail and wipe out Capitalism and all its evils.

"We are part of the stream of history," a Socialist orator said recently. "Do not anybody despair because of our small numbers or because the movement of the left in general is so isolated today. We are like the American abolitionists of a hundred years ago. These men earned

fame and immortality and their crusade triumphed because they were intrepid fighters and heroes of vast stature and because — what is decisive — the antislavery cause coincided with the line of march of the American republic.”

Another writer phrased it this way: “Not only could the existing structure be fitted to a slave and to a capitalist economy; it could likewise be fitted to one whose voters were exclusively whites or to one which enfranchised Negroes. Thus the Constitution of the United States is a mechanical framework which fits different economic systems. In view of what the Supreme Court has already said on the subject of state regulation and ownership of business, there is little doubt that it will fit a socialist economy.”

If the usual pattern of Socialist propaganda is followed, that destructive idea will soon be added to the others which have filtered down through the egghead liberals and other fellow travelers who are responsible for much of the creeping socialism in our government today.

Medicine must be on the alert to fight it every where it shows its head. Communism, in fact, is only one sector of the real enemy, Socialism.

#### **For Your Information**

The National Chiropractic Association of Webster City, Iowa, recently began a series of full-page advertisements in *Editor & Publisher*, weekly journal of newspaperdom. The various presentations in the series include some amusing and some malicious distortions of fact, intended obviously to validate the teaching of the cult, and the whole series is apparently intended as a bid to the newspapers for chiropractic publicity during its national correct posture week (May 1-7). This week is devoted to teaching that “long life and sound health are inherent in correct posture.”

It is not to be expected, of course, that any physicians will be inveigled into lending their names and reputations to any such promotion and certainly few newspapers will be susceptible to such petty bribery. However, the series is interesting as an exposition of current cultist propaganda. Some of the claims made:

That there are now nearly 25,000 chiropractors who treat “some 2,000,000 new patients annually.”

That Hippocrates started it all by remarking that one should “look well to the spine for cause

of disease,” and that chiropractic “was actually in use many years B.C. in Greece.”

That the Hippocratic verdict was lost sight of until rediscovered by chiropractors in 1895, when “a fresh concept in the art of healing, based upon the physical and mechanical approach, rather than the chemical, was given to the world.”

(There is severe distortion or subluxation, as the chiros call it, in those last two clauses. The teachings of the Hippocratic school were based on the doctrine of humors and their balance or imbalance, while the Greeks used drugs, purgatives and emetics, venesection, surgery and other procedures forbidden to the chiros by definition. That suggests that the spine quotation has been torn from its context and twisted to mean that Hippocrates invented and used chiropractic. That is easy to do, since the Hippocratic texts actually were the product of many minds and written over a period probably of several hundred years.)

That chiropractic has earned its place as the second largest healing profession and that through it “a major battle in man’s war against disease and sickness has been won.”

(Which battle has been won by the cultists? The control of bacterial disease with antibiotics, of polio, smallpox and rabies with vaccine, of cancer by surgery and radiation, etc.?)

That “it started with Plato,” in the second ad of the series, which says that he broke the bounds of superstition and taught investigation. (Plato taught a doctrine of master and slave and Aristotle would have been a better choice for the copywriter.)

Other ads in the series emphasize the four-year, 4000-hour curriculum of the chiropractic schools, which “compare favorably with those in other scientific and professional fields.”

Summing up: The guff about Hippocrates and Plato is designed merely to give an aura of scientific orthodoxy to the chiro cult. But the malicious implication that the medical profession is bound to a “chemical approach” to disease and does not know about the co-ordinating function of the nervous system is the real core of the propaganda.

And oh, yes, some one should tell them that “chiropractic” does not come from Greek words meaning “efficient hand.” It comes from the

word for "hand" and the verb meaning "to do or perform," the same verb represented in words like "practical" and "practise", and thus means "hand-operated", as in massage.

#### **PR Goals of Medicine Restated by AMA**

A recent AMA publication outlined the most important public relations goals for 1954. They warrant widespread publicity within the medical profession and for that reason are summarized here:

Goal One: Spread the public relations concept more widely throughout the medical profession.

Goal Two: Develop a stronger, more unified profession, indoctrination programs, more member activity, a united front on all medical issues.

Goal Three: Utilize every PR outlet to tell the story of medicine — press, radio, television, health forums, speakers' bureau, exhibits.

Goal Four: Mend medicine's fences to eliminate complaints.

As the AMA remarks, these are guideposts and each county medical society must scrutinize its own problems and tailor its program to fit the needs of its own community.

It was with this type of program in mind that your Committee on Medical Service and

Public Relations prepared its pamphlet on the PR programs of county medical societies, which outlines the many techniques available for use in these difficult days and situations. If you have not seen it, a postcard to Room 902, 185 North Wabash Avenue, Chicago 1, will bring you as many as you need.

#### **Quoted by Permission**

Listen to the promises of the planners, do-gooders and socializers to reduce all death rates and prolong life indefinitely if we will just let them run everything. Just give us a few more millions, they tell us, and we'll keep you from dying of thisitis or thatosis and also take death out of old age. They quote you statistics to prove it.

If their promises were carried out, Utopia would take the form of a deathless state in which all our energies would be devoted to maintaining the spark of life in millions of aged vegetables. Shall it be that way? Probably not.

The one final implacable statistic which the planners try to hide is that the death rate is and always will be 100 per cent.

That leaves me wondering, as I listen, just what they want us to die of — and when.

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### **FORMULA FOR SUCCESS**

Thorough knowledge of our profession is absolutely essential, but if I am asked to give the best formula for success, I will answer unqualifiedly, "The knowledge of how to handle your patients." Unfortunately, this is not a science taught in medical schools now, although when I entered the College of Physicians and Surgeons in 1886, students could obtain credit if, before their graduation, they could bring in a certificate

from their preceptor, a practicing physician, stating that the student had accompanied him on his rounds visiting private patients. I have known quite a few medical men who were walking medical libraries but who never could build up a practice because they lacked the know-how of gaining a patient's confidence. It is a science that only experience and love of mankind can develop. *Joseph D. Nagel, M.D., Memories of A. G. P.'S 65 Years in New York City. New York J. Med. Jan. 15, 1954.*

# CORRESPONDENCE



## N.U. FACULTY-ALUMNI DINNER

Northwestern University Medical Annual Faculty-Alumni Reunion dinner, Saturday evening, *May 22*, The Drake Hotel, Chicago. Social period at 5:30 p.m. and dinner at 7:00 p.m. Dinner tickets \$9.00 a plate; wives also invited to attend. Entertainment by Medical students entitled, "Quo Vadis Medicus? The History of Medicine." Make reservations at Medical Alumni Office, 303 E. Chicago Ave., Chicago 11, before May 19.

## CLINICS FOR CRIPPLED CHILDREN LISTED FOR JUNE

Eighteen clinics for Illinois' physically handicapped children have been scheduled for June by the University of Illinois Division of Services for Crippled Children. The Division will count 12 general clinics providing diagnostic orthopedic, pediatric, speech and hearing examinations along with medical social and nursing services. There will be 4 special clinics for children with rheumatic fever and 2 for cerebral palsied children.

Clinics are held by the Division in cooperation with local medical and health organizations, both public and private. Clinicians are selected among private physicians who are certified Board members. Any private physician may refer to or bring to a convenient clinic any child or children for whom he may want examination or

may want to receive consultative services.

The June clinics are:

June 2 — Hinsdale, Hinsdale Sanitarium

June 2 — Rock Island (Cerebral Palsy), Foss Home, 3808-8th Ave.

June 3 — Litchfield, St. Francis Hospital

June 8 — East St. Louis, Christian Welfare Hospital

June 8 — Peoria, St. Francis Children's Hospital

June 10 — Elmhurst (Rheumatic Fever), Memorial Hospital of DuPage County

June 10 — Fairfield, Fairfield Memorial Hospital

June 10 — Springfield, St. John's Hospital

June 11 — Chicago Heights (Rheumatic Fever), St. James Hospital

June 15 — Salem, Masonic Building

June 16 — Chicago Heights, St. James Hospital

June 17 — Rockford, St. Anthony's Hospital

June 22 — Effingham (Rheumatic Fever), St. Anthony's Memorial Hospital

June 22 — Peoria, St. Francis Children's Hospital

June 23 — Elgin, Sherman Hospital

June 23 — Springfield (Cerebral Palsy), Memorial Hospital

June 24 — Bloomington, St. Joseph's Hospital

June 25 — Chicago Heights (Rheumatic Fever), St. James Hospital

In carrying on its program the Division works cooperatively with local medical societies, hospitals, the Illinois Children's Hospital-School and civic and fraternal clubs, visiting nurse associations, local social and welfare agencies, local chapters of the National Foundation for Infantile Paralysis and other interested groups.

In all cases, the work of the Division is intended to extend and supplement — not supplant — activities of other agencies, either public or private, state or local, carried on in behalf of crippled children.

The Division of Services for Crippled Children is the official state agency established to provide medical, surgical and corrective and other services and facilities for diagnosis, hospitalization, and after-care for children who are crippled or who are suffering from conditions which may lead to crippling.

### **SESSION ON LEGAL MEDICINE AT SAN FRANCISCO MEETING**

In recognition of the growing importance of the many situations in which medicine may contribute to a clarification of medicolegal issues and of the interest and concern of physicians in such situations, there will be presented at the San Francisco meeting in June a Session on Legal Medicine in the Section on Miscellaneous Topics of the Scientific Assembly. This Session will be held under the immediate sponsorship and direction of the Committee on Medicolegal Problems which has arranged an informative program to include discussions on topics of practical value to practitioners who, whether they like it or not, will some day become personally concerned in a medicolegal involvement. The following papers will be presented:

*Advice to the Medical Witness*, W. I. Gilbert, Esq., President, Los Angeles Bar Association; *Malpractice, an Occupational Hazard*, Louis J. Regan, M.D.; *Medicolegal Problems Related to Sterilization, Artificial Insemination and Abortion*, J. W. Holloway, Jr., Esq., and Edwin J. Holman, Esq.; *Prevention of Transfusion Accidents*, Alexander S. Wiener, M.D.; *Legal Aspects of Medical Partnerships*, George E. Hall, Esq.; *Trauma, Stress and Coronary Thrombosis*, Alan R. Moritz, M.D.

This Session represents a practical and some-

what new approach to a solution of some of the situations in the medicolegal field that have caused, or that in the future may cause uncertainty and possible embarrassment on the part of the physician. The program has been carefully arranged with that objective in mind and a physician will find much of value in the six papers. The meeting will be held on Thursday morning, June 24, in the White Room of the Masonic Temple located at 25 Van Ness Avenue and will begin at 9:00 a.m. and conclude at 12:00 noon.

### **PROFESSIONAL FILMS AND AUTHORS**

To assure the listing of *all* outstanding professional 16mm films — regardless of availability — in the forthcoming "Directory of Professional Motion Picture Films and Authors" now being compiled, all film authors are urgently requested to immediately write for film questionnaires. Other members of the profession are invited to cooperate in this endeavor by forwarding this announcement to an author or by directly providing the film title and name and address of any film author. Please send your valuable information to: Professional Publications, Compilation Department, 2010 Kentucky Street, Lawrence, Kansas.

### **CONGRESS ON OBSTETRICS AND GYNECOLOGY DECEMBER 13-17**

The sixth American Congress on Obstetrics and Gynecology will be held at the Palmer House, Chicago, December 13-17, 1954.

The five-day meeting is sponsored by the American Committee on Maternal Welfare, Inc., and the American Academy of Obstetrics and Gynecology. It will bring together the four major groups concerned in the provision of better care for mothers and babies — medicine, nursing, public health and hospital administration.

The program will include twenty-seven formal papers, twenty-two symposia and panels, luncheon discussion groups, and several hundred round-table discussions, covering every phase of maternal and newborn care. Scientific and technical exhibits are also being planned.

Information about the meeting may be obtained by writing to the Sixth American Congress on Obstetrics and Gynecology, 116 South Michigan Avenue, Chicago 3, Illinois.

## **ANNUAL MEETING OF ACADEMY OF PSYCHOSOMATIC MEDICINE**

The Program of the first annual meeting of the Academy of Psychosomatic Medicine, to be held at the Plaza Hotel in New York City on October 8-9, 1954, will be devoted to *Psychosomatic Aspects of Surgery*. There will be contributed and invited papers on such topics as: Psychosomatic Aspects of Anesthesia; General Surgery; Gynecological Surgery; Plastic, Otolaryngological and Oral Surgery; Mutilating Operations; Endoscopic Surgery; Orthopedic Surgery; Eye Surgery; Pediatric and Geriatric Surgery; and Neurological Surgery.

Those who are interested in presenting papers should write to Dr. Benjamin Raginsky, 376 Redfern Ave., Montreal, Canada, stating their special interest.

## **FELLOWSHIPS FOR GRADUATE REGISTERED NURSES**

The Illinois Division of the American Cancer Society announces the establishment of four fellowships to enable graduate registered nurses to take intensive training in the team approach to cancer nursing education at New York University Memorial Center. The amount of each fellowship will be \$600 to defray the cost of transportation, maintenance, tuition, and fees. The course will be given in October 1954 and will be of six weeks duration.

Candidates for these fellowships should be graduate registered nurses employed as faculty members in a School of Nursing or faculty members of nursing departments in colleges and universities. Preference will be given to applicants in key positions in the State, with broad educational background and teaching experience.

Recipients of the fellowships will be expected to contribute to the Cancer Control Program in Illinois through occasional participation in the Illinois Division's symposia for nurses and in their own school of nursing program.

For further information and application forms

write to: Emily C. Cardew, Member, Medical and Scientific Committee, American Cancer Society, Illinois Division, Inc., 139 North Clark Street, Chicago 2, Illinois.

## **INTENSIVE STUTTERING THERAPY PROGRAM**

An intensive program of therapy for the college-age male stutterer is being offered again by the Speech Clinic at Northwestern University for the summer of 1954. This program is designed to bring into focus the best of recent developments in stuttering therapy. This will be a residential program requiring full time attendance and will be staffed by professional clinicians with extensive experience in stuttering therapy.

Clinicians will meet with each individual stutterer several hours daily and both group and individual experiences will be developed. Practical application of new speech and adjustment techniques will be emphasized. An "experience therapy" outside the clinic setting will be stressed in a program that will average nearly eight hours daily for the stutterer for the nine-week period, June 21 - August 7, 1954.

Arrangements can be made for students to live in the regular University student housing on campus, and the usual privileges of student use of University recreation and other facilities will be extended to members of the program. The members of the program residing on campus will be governed by the usual rules of conduct covering the student body in residence.

A low clinician-stutterer ratio will be maintained to emphasize the adaption of the program to the individual stutterer and to permit intensive application of new speech and adjustment patterns. Registration is strictly limited.

For further details and arrangements write: Charles R. Elliott, Associate Director, Speech Clinic, School of Speech, Northwestern University, Evanston, Illinois.

## NEWS OF THE STATE



### ADAMS

**Society News.**—The Adams County Medical Society was addressed at a dinner meeting, March 8, in the Lincoln Douglas Hotel, Quincy, by Dr. Robert S. Myers, Boston, administrative assistant of the American College of Surgeons on "Joint Commission on Hospital Accreditation and Your Hospitals." Dr Myers was optimistic regarding the Quincy hospitals and the progress the medical staffs were making locally to improve hospital care. The meeting was attended by members of the hospital administrating staffs of Quincy and the Illini Hospital of Pittsfield. At another recent meeting of the society, Dr. Edwin N. Irons, clinical assistant professor of medicine, University of Illinois College of Medicine, spoke on heart disease. At the business meeting, the society went on record approving the membership campaigns of Blue Cross and Blue Shield for hospitalization and medical care insurance. It also elected Dr. J. Richard Cooper, Quincy, to membership.

**Dr. Montgomery Chosen County Outstanding Practitioner.**—Dr. Edmund B. Montgomery, Quincy, was chosen "outstanding general practitioner" of Adams County.

### CLINTON

**Society News.**—Dr. Willis I. Lewis, Herrin, President of the Illinois State Medical Society, addressed the Clinton County Medical Society recently. According to Dr. J. Q. Roane, secretary of the county society, this was the first time in the history of the society since it was organized May 2, 1876 that a state president was its guest. Dr. Max Hirschfelder, Centralia, addressed the society recently on "Rural Ophthalmology."

### CHRISTIAN

**Society News.**—Dr. Robert M. Goodwin, Springfield, addressed the Christian County Medical Society in Taylorville, February 9, on "Tumors of the Skin."

### COOK

**Zeit Lecture.**—Dr. Karl Menninger, Topeka, delivered the twelfth annual Robert F. Zeit Lecture in Thorne Hall, Northwestern University Medical School, April 5, on "Anxiety versus Pain." The lecture was sponsored by Xi Chapter, Alpha Kappa Kappa Fraternity.

**Fifth Annual Tuberculosis Conference.**—The Tuberculosis Institute of Chicago and Cook County held its fifth annual tuberculosis conference at the Sherman Hotel, May 18-19. The various sessions were presented under the following titles: Changing Concepts in Tuberculosis Care and Control; Personality Needs and the Rehabilitation Process; Big City T.B. Care—The Chicago Story; Tuberculosis—A Community Problem: The People—How Much Do They Know About Tuberculosis; Chemotherapy—A New Tonic for Health Educators, and I Had Tuberculosis, a case history feature.

**Physicians Honored.**—Dr. Walter L. Palmer, professor of medicine, and Dr. William E. Adams, professor of surgery, both at the University of Chicago School of Medicine, were named to new professorships recently. Dr. Palmer was named the recipient of the Distinguished Richard T. Crane Professorship in Medicine, and Dr. Adams, the James Nelson and Anna Louise Raymond Professor of Surgery. Both physicians have made extensive scientific contributions to their respective fields.

**George Hellmuth Goes to Milwaukee.**—Dr.

George Hellmuth, Chicago, Chairman of the Post-graduate Education Committee of the Illinois State Medical Society, has accepted an appointment as associate clinical professor of medicine and chief of the cardiovascular section in the department of medicine of Marquette University School of Medicine, Milwaukee. The appointment is effective September 1. Dr. Hellmuth will also serve a concurrent appointment as head of the heart service of the Milwaukee County General Hospital and the Milwaukee Dispensary.

**Interns and Matching Plan**—One hundred and thirty-three seniors in the University of Illinois College of Medicine who participated in the matching plan for hospital internships received their first preference.

Dean of Students Maurice J. Galbraith reported that a higher percentage of students received preferences this year than a year ago. One hundred and forty-six University of Illinois students participated in the matching plan.

In addition to those who were matched to the hospital of their choice, 11 students received their second preference. Only two students were not matched. These two students have received a great number of invitations from hospitals in the past few days.

Cook County Hospital was the most common choice of the students. Forty-six seniors will intern there. Nine students will intern at the University of Illinois Research and Educational Hospitals.

Students are matched for internships through the National Inter-association Committee on Internships. In this plan, internship appointments are made by matching the preference of the student for a hospital with the preference of the hospital for that student.

**Personal**—Dr. Morris H. Kreeger, executive director of Michael Reese Hospital, has been named president of the Chicago Hospital Council.—Dr. Paul C. Bucy, professor of neurology and neurological surgery at the University of Illinois College of Medicine, is on a three month visit to South America where he will participate in several professional meetings and serve as visiting director at the Neurological Institute to be held by the University of Uruguay at Montevideo and visiting professor of neurological surgery at the University of Minas Gerais in Brazil.

**Dr. Drabkin Gives McArthur Lecture**—The thirtieth Lewis Linn McArthur Lecture was delivered by Dr. David L. Drabkin, professor and chairman of the department of physiological chemistry, Graduate School of Medicine, University of Pennsylvania, May 10. Title of the lecture was "Thudichum, a Neglected Medical Genius of the Nineteenth Century."

**Medicine and the Humanities**—The Chicago Medical School launched a series of lectures on "Medicine and the Humanities", April 6, with a

talk by Dr. Noah D. Fabricant, assistant professor of otorhinolaryngology, University of Illinois College of Medicine, on "Why We Became Doctors (Motivations as Revealed in Literature)." Other lectures included:

Religio Medici, 1954, Samuel J. Zakon, professor of dermatology, Northwestern University Medical School, April 13.

Medical Symbolism in Painting and Sculpture, Leo M. Zimmerman, professor and co-chairman of the department of surgery, Chicago Medical School, April 20.

Disease and Art, Ilse Veith, assistant professor of history of medicine, University of Chicago School of Medicine, April 27.

Resurrectionists, Leslie B. Arey, professor of anatomy, Northwestern University Medical School, May 4.

Medical Caricatures, Israel Davidsohn, professor of pathology, Chicago Medical School, May 11.

Milk Sickness, Frederick Stenn, lecturer in history of medicine, University of Illinois College of Medicine, May 18.

## LAKE

**New Call System**—The Lake County Medical Society has established a call system for emergency care at the Victory Memorial Hospital. The telephone number is Majestic 3-4000. Physicians making up the roster will be on call for twenty-four hour periods as their names come up. Reasons of health may be submitted to the Secretary of the county society for withdrawal of name. According to the Bulletin of the Lake County Medical Society, physicians may volunteer for extra service if they so desire.

## LOGAN

**Hospital Dedicated**—Dr. Roland R. Cross, director of the Illinois Department of Public Health, gave the dedicatory address of Abraham Lincoln Memorial Hospital at Lincoln April 2. The new 104-bed general hospital was built at a cost of \$1,765,000. Of this, \$915,000 was provided by the voluntary donations of the people of Logan county. The state gave \$190,400 under the Illinois plan for participation in the hospital construction program sponsored by the federal government. The federal share of this project was \$659,600. Dr. Cross termed the new Lincoln hospital "a beautiful and lasting monument to sound community thinking and planning."

## MACON

**Society News**—"High Energy Radiation Therapy of Malignant Disease" was discussed by Dr. Edward H. Reinhard before the Macon County Medical Society at the Decatur Club, March 23. Dr. Reinhard is assistant professor of radiology at Washington University Medical School.

## MADISON

**Society News.**—Dr. John E. Hobbs, associate professor of clinical obstetrics and gynecology, Washington University School of Medicine, St. Louis, discussed "The Menopause—Plan for Management" at the February meeting of the Madison County Medical Society in Edwardsville.

**Regional Heart Meeting.**—The Illinois Heart Association sponsored a regional conference at the Strafford Hotel, Alton, March 4. Speakers included Carl J. Marienfeld, Chicago, on "Latest Development in the Diagnosis and Treatment of Rheumatic Fever"; Robert Payne, St. Louis, Heart Disease in Pregnancy; Albert I. Lansing, St. Louis, Etiology of Arteriosclerosis. In the evening Warren F. Pearce, Quincy, discussed "The Program of the Illinois Heart Association and How It Serves the Physician", and Henry A. Schroeder, St. Louis, "New Aspects in the Treatment of Hypertension."

**Society News.**—Dr. Arthur C. Simons, Decatur, discussed "Urologic Problems in Childhood" before the Madison County Medical Society at St. John's Methodist Church, Edwardsville, April 1.

## PEORIA

**Society News.**—Dr. William J. Baker, Chicago, addressed the Peoria Medical Society at the Hotel Pere Marquette, April 20, on "Carcinoma of the Prostate."

**Personal.**—Dr. Jay J. Welch recently opened offices at 630 Jefferson Building, Peoria, with his practice limited to internal medicine.

## STARK

**Dr. Berfield Honored.**—Dr. Clyde Berfield, Toulon, was inducted in the Fifty Year Club of the Illinois State Medical Society during a postgraduate conference in Kewanee, April 15. Insignia emblematic of the honor was presented to Dr. Berfield by Dr. Charles P. Blair, Monmouth, Councilor of the Fourth District of the Illinois State Medical Society.

## ROCK ISLAND

**Staff Election.**—Dr. A. Walter Wise, Rock Island, was recently elected president of the St. Anthony's Hospital staff for 1954, succeeding Dr. R. T. Boysen, also of Rock Island. Other officers are Drs. H. T. Kutsunis, vice president, and J. S. Roane, secretary. Both are from Rock Island.

**Hospital Opens New Addition.**—St. Anthony's Hospital, Rock Island, recently opened an eighty bed addition, which gives the institution a total 264 bed capacity. The new wing offers twenty-six beds for pediatric patients. The first floor is devoted to administrative offices, physicians' library, waiting room and pharmacy. Other floors contain facilities for an orthopedic operating room with an adjacent splint room and developing room for x-ray films; a complete new pediatric department

with private rooms and several four-bed wards; a treatment room with complete facilities for pediatric care and a large play and recreation room. The fourth floor takes up the maternity department.

**Drive for Expansion Funds.**—Moline Lutheran Hospital has launched a drive to collect \$475,000 to finance construction of a new wing for the hospital, remodeling parts of the present building, additional equipment and some redecoration. Total cost is set at \$775,000, but \$300,000 is available currently from reserves, gifts and bequests. Plans for the new wing call for a basement and two full floors.

## SANGAMON

**Personal.**—Dr. J. E. Reisch, Springfield, was one of a group of judges who chose the winning essay on tuberculosis in the 1954 state-wide contest for school children. Dr. Reisch officiated in his capacity as president of the American Medical Writers' Association.

**Society News.**—"Acute Surgical Problems in the Newborn and Infant" was discussed by Dr. Clifford D. Benson before the April 1 meeting of the Sangamon County Medical Society at a dinner meeting in the Elks Club, Springfield. Dr. Benson is assistant professor of clinical surgery at Wayne University College of Medicine, Detroit. The society was addressed in March by Dr. Banning G. Largy, instructor in surgery, University of Illinois College of Medicine, on "Newer Aspects of Peripheral Vascular Disease."—At the annual meeting of the Springfield Medical Club in the Hotel Abraham Lincoln, Springfield, March 11, Dr. Lee M. Eaton, Rochester, Minn., spoke on "Poliomyelitis."

## VERMILION

**Society News.**—"Diagnosis of Asymptomatic Cancer" was the subject of an address before the Vermilion County Medical Society in Danville, March 2, by Dr. George Milles, pathologist of Augustana Hospital, Chicago, and president of the Chicago Pathological Society.—The Society was addressed April 6 in Danville by Dr. Samuel M. Feinberg, Chicago, on "Food Allergy."

## WINNEBAGO

**Society News.**—Dr. Harvey S. Allen, Chicago, discussed "Treatment of Burns" before the Winnebago County Medical Society at the Rockford Country Club, Rockford, April 13.

## GENERAL

**Tuberculosis Decreases.**—A 21 per cent decrease in the number of deaths from tuberculosis during 1953 as compared to 1952 was reported by the Illinois Department of Public Health.

The total number of tuberculosis deaths of Illinois residents exclusive of those who died outside the state was 1,210 last year, according to Dr. Roland R. Cross, state health director. Of this total, 794 were in Chicago and 416 in the remainder of the state. In 1952, there were 1,547 deaths, of

which 1,060 were in Chicago and 487 downstate.

The provisional death rate for Illinois from tuberculosis is 13.4 per hundred thousand population; for Chicago, 21.4; for downstate, 7.8 per hundred thousand.

This represents approximate declines of 25 per cent in Chicago, 16 per cent downstate and 21 per cent for the entire state, Dr. Cross said.

Of the total number of tuberculosis deaths in Illinois, only 50, or 4.1 per cent, occurred among residents under 20 years of age. Of these 50 deaths, 34 occurred among children under five years of age. Thus, there were only 16 deaths last year from tuberculosis among Illinois children from kindergarten through high school age.

Death rates per 100,000 population have dropped steadily during recent years in Illinois. Compared to the 1953 provisional figure of 13.4 are the following rates for the previous 10 years; 1952, 18.7; 1951, 21.5; 1950, 25.4; 1949, 29.6; 1948, 32.0; 1947, 35.2; 1946, 38.6; 1945, 40.9; 1944, 41.9; 1943, 43.8. The 1933 rate was 54.1; 1923, 82.0; 1920, 100.5; 1917, 129.4 deaths per 100,000 population.

The state health department operates two tuberculosis sanitariums. A 100-bed institution at Mt. Vernon has been filled to about capacity with a waiting list of between 10 and 25 cases from southern Illinois. A 450-bed hospital in Chicago which opened last fall now has more than 100 patients. Additional beds at Chicago are being made available as fast as additional physicians and nurses can be obtained.

It is estimated that approximately 1,200,000 x-rays were taken during 1953 by mobile units operated by the state health department and other agencies and hospitals throughout the state.

**Pilot Programs for Aged.**—Peoria, Stephenson and Scott counties were chosen by the Illinois Public Aid Commission as a "proving ground" for new programs designed to help keep the increasing group of aging persons happy. Meetings at the local level were to have begun in April, it was announced at a meeting of the Advisory Committee on Aging of the Illinois Public Aid Commission, March 23. Local county welfare services will direct the program organization, with cooperation from local business organizations, medical services, church groups, woman's clubs, parks and other local governments. The program is aimed to interest elderly people in recreational activities before they definitely are in the class of aged persons. According to the Chicago Daily News, "activities in them include square dancing, ceramics, games, great book courses and many others. All are social in character and enable many persons to find refreshing friendships in the world they once suspected of leaving behind."

**Postgraduate Conferences.**—The Postgraduate Education Committee of the Illinois State Medical Society recently sponsored a series of conferences

throughout the state. The following program were presented in cooperation with the agency indicated:

With the Richland County Medical Society as host and in cooperation with Stritch School of Medicine of Loyola University, in Olney, April 30: William F. Cernock, Diagnosis and Treatment of Liver Disease, and Peter J. Talso, Common Problems of Electrolytic Metabolism; James J. Duffy, Common Neurological Disorders."

With the Lake County Medical Society as host and in cooperation with Chicago Medical School in Waukegan, April 21: Donald Atlas, Peter Gaberman, Albert J. Levine, Ernest B. Zeisler, panel on hypertension; David Cohen, David Fisher, Harry H. Garner, panel on diseases of the surface of the body; Leo Zimmerman, Harry A. Weisberg and A. Robert Goldfarb, panel on Thyroid Disease. Evening speaker Francis J. Mullin, Ph.D., "Grave Problems in the Training of Surgeons."

With the Coles-Cumberland County Medical Society as host in cooperation with the staff of St. Luke's Hospital in Mattoon, April 29: Fred E. Ball, James W. Clark and William K. Scupham, panel on hypertension; E. Lee Strohl, Surgery in the Aged; John H. Pribble, Acute Abdominal Trauma, and Charles V. Heck, General Principles of Fracture Management; evening speaker, Paul H. Holinger, Unusual Experiences in Bronchology.

With the Rock Island County Medical Society as host and in cooperation with the Iowa-Illinois Central Medical Society and the staff of the Presbyterian Hospital, Chicago in Moline, March 31: Edwin N. Irons, John S. Graettinger, John W. Clark, Edward J. Beattie, Jr., panel on cardiovascular disease; George W. Stuppy, John W. Clark, Edward J. Beattie, Robert M. Kark and James A. Campbell, panel discussion on gastrointestinal disease; Drs. Campbell, Karl, Beattie and Samuel G. Taylor, III, panel on endocrine diseases. Evening speakers, Charles P. Blair, Monmouth, Councilor, Fourth District of the Illinois State Medical Society, "Medical Organizations," and Henry L. Williams, professor of otolaryngology and rhinology, Mayo Clinic, "Dizziness."

With the Henry County Medical Society as host and in cooperation with the University of Illinois College of Medicine, in Kewanee, April 15: Ford K. Hick, Ormand C. Julian and Max Sadove, Medical Management, Surgical Management and Anesthetic and Operative Management of the Cardiovascular Patient, respectively.

**"Your Doctor Speaks"** over FM Station WFJL.—Since the last issue of the Illinois Medical Journal, the following physicians have appeared in transcribed broadcasts in the series "Your Doctor Speaks", presented by the Educational Committee of the Illinois State Medical Society in cooperation with FM Station WFJL:

Henry M. Apfelbach, clinical instructor in orthopedic surgery, University of Illinois College of

Medicine, March 18, Hip Fractures in the Aged.

**E. Lee Strohl**, attending surgeon, St. Luke's Hospital, March 25, on Problems of Surgery in the Elderly Patient.

**Donald S. Miller**, professor of orthopedic and traumatic surgery, Chicago Medical School, April 1, on Pain in and About the Shoulder.

**Stanley Fahlstrom**, assistant clinical professor of medicine, Stritch School of Medicine of Loyola University, April 8, on Arthritis.

**Louis W. Schultz**, clinical associate professor of oral surgery, University of Illinois College of Medicine, April 15, on Congenital Deformities.

**Lectures Arranged Through the Education Committee of the Illinois State Medical Society:**

**Paul K. Anthony**, Youth Week for the Board of Education, Cornell Elementary School, May 14, Health and Personality.

**Henry A. Dollear**, Jacksonville, Washington County Health Improvement Association, April 23, on Drug Addiction.

**Eugene L. Slotkowski**, Chicago, Providence High School Seniors, April 26, on Mental Health.

**Vincent D. Pollard**, Decatur, Longview Lions Club, May 24, on Health of the School Child.

**George V. Byfield**, Chicago, St. Paul's Church "Friendly Seniors" in Chicago, May 25, on Maintaining Health After Sixty.

**Alfred Biggs**, Youth Week Lecture for the Board of Education, Gage Park High School, May 11, Teen Age Tips on Health.

**Philip Rosenblum and Lawrence Breslow**, Youth Week Lectures for the Board of Education, Yates Elementary School, May 14, on Health and Personality.

**Felix Tornabene**, Aurora, Elmhurst Kiwanis Club in Elmhurst, May 4, on Advances in Medicine.

**Lectures Arranged Through the Scientific Service Committee of the Illinois State Medical Society:**

**John R. Wolff**, Chicago, La Salle County Medical Society in La Salle, April 8, on Anemias of Pregnancy.

**Leonard F. Jourdonais**, Evanston, Kane County Medical Society in St. Charles, April 14, on Diabetes.

**George M. Cummins**, Chicago, Rock Island Chapter, Illinois Academy of General Practice in Moline, April 27, on Cardiovascular Aspects of Aging.

**Earl Garside**, Chicago, Marion County Medical Society in Centralia, June 17, on Acute Obstruction of the Colon with Particular Reference to Fluid Balance.

**E. Harold Ennis**, Springfield, Whiteside-Lee County Medical Societies in Sterling, June 17, on Office Gynecology.

**"All About Baby" over WBKB, Channel 7.**—Since the last issue of the Illinois Medical Journal, the following physicians were invited by the Educational Committee to appear in the telecast "All

About Baby," a feature on Channel 7, Station: WBKB.

**Noel G. Shaw**, Evanston, head of the pediatric staff, St. Francis Hospital, March 17.

**Jennie K. Amtman**, associate attending physician, Children's Memorial Hospital, April 14.

**Harold X. Gerber**, instructor in pediatrics, Chicago Medical School, April 7.

**J. Joseph Baratz**, clinical assistant professor of pediatrics, University of Illinois College of Medicine, April 21.

## DEATHS

Clifford Bullen, Oak Park, who graduated at the University of Illinois College of Medicine in 1908, died April 6, aged 74.

Mandel Fisher, Chicago, who graduated at Bennett Medical College in 1914, died in Phoenix, Arizona, March 17, aged 76. He was a member of the Illinois State Medical Society.

Howard C. Hoag, retired, Waukegan, who graduated at Loyola University School of Medicine in 1918, died March 25, aged 66. He was a member of the Illinois State Medical Society and a former president of the Lake County Medical Society.

Sandor Horwitz, Peoria, who graduated at Missouri Medical College, St. Louis, in 1895, died January 17, aged 86, of coronary thrombosis. He was a member of the Illinois State Medical Society; formerly district health officer for the state board of health, and health commissioner of Peoria.

Thomas G. Jones, retired, Chicago, who graduated at Bennett Medical College in 1912, died April 7, aged 66. He was a member of the Illinois State Medical Society and, until his retirement four years ago, a member of the staff of Englewood Hospital.

Jacob D. Lifschutz, Chicago, who graduated at the University of Illinois College of Medicine in 1916, died March 31, aged 64. He was a member of the Illinois State Medical Society and of the staffs of Michael Reese and Lutheran Deaconess Hospitals.

George J. Lorch, retired, Diamond Lake, who graduated at the College of Physicians and Surgeons of Chicago, School of Medicine of the University of Illinois, died April 2, aged 79.

John Woods Marchildon, McClure, who graduated at Rush Medical College in 1903, died in Cape Girardeau, Missouri, January 29, aged 77. He was a member of the Illinois State Medical Society and formerly on the faculty of St. Louis University School of Medicine.

Benjamin V. Marquis, Buffalo Prairie, who graduated at Missouri Medical College, St. Louis, in 1898, died February 13, aged 82. He was a member of the "Fifty Year Club" of the Illinois State Medical Society.

Earl S. Meloy, Highland, who graduated at the Chicago College of Medicine and Surgery in 1913, died March 5, aged 65. He was a member of the Illinois State Medical Society, and of the Board of Trustees of the Madison County Tuberculosis Sanatorium for 22 years.

Oliver S. Ormsby, retired, Chicago, who graduated at Rush Medical College in 1895, died April 9, aged 80. He was a member of the Illinois State Medical Society and professor emeritus of dermatology at the University of Illinois College of Medicine.

Stanley W. Parowski, Chicago, who graduated at the Chicago College of Medicine and Surgery in 1905, died March 15, aged 80. He was a member of the Illinois State Medical Society.

Russell Arthur Quay, Stanford, who graduated at Northwestern University Medical School in 1946, died in St. Joseph's Hospital, Bloomington, January 3, aged 37, of bulbar poliomyelitis. He was a member of the Illinois State Medical Society and affiliated with Brokaw Hospital in Normal and the Mennonite Hospital in Bloomington.

Hilda L. Ridler, Rock Island, who graduated at Medizinische Fakultät der Universität, Wien, Austria, in 1915, died recently, aged 65. She was a member of the Illinois State Medical Society.

David Roscoe Scott, Chicago, who graduated at University Medical College of Kansas City, Missouri, in 1911, died February 5, aged 68. He was a member of

the Illinois State Medical Society and of the staff of the Norwegian American Hospital.

George Edwin Southwick, Chatham, who graduated at Miami Medical College, Cincinnati, in 1892, died January 19, aged 85.

Elmer M. Thomas, Aurora, who graduated at the University of Illinois College of Medicine in 1914, died March 23, aged 68. He was a member of the Illinois State Medical Society.

Willard O. Thompson, Chicago, who graduated at Harvard Medical School in 1923, died March 23, aged 55. He was a member of the Illinois State Medical Society, formerly president of the Chicago Medical Society, clinical professor of medicine at the University of Illinois College of Medicine, and on the staffs of Grant, Henrotin, and Illinois Research and Educational Hospitals.

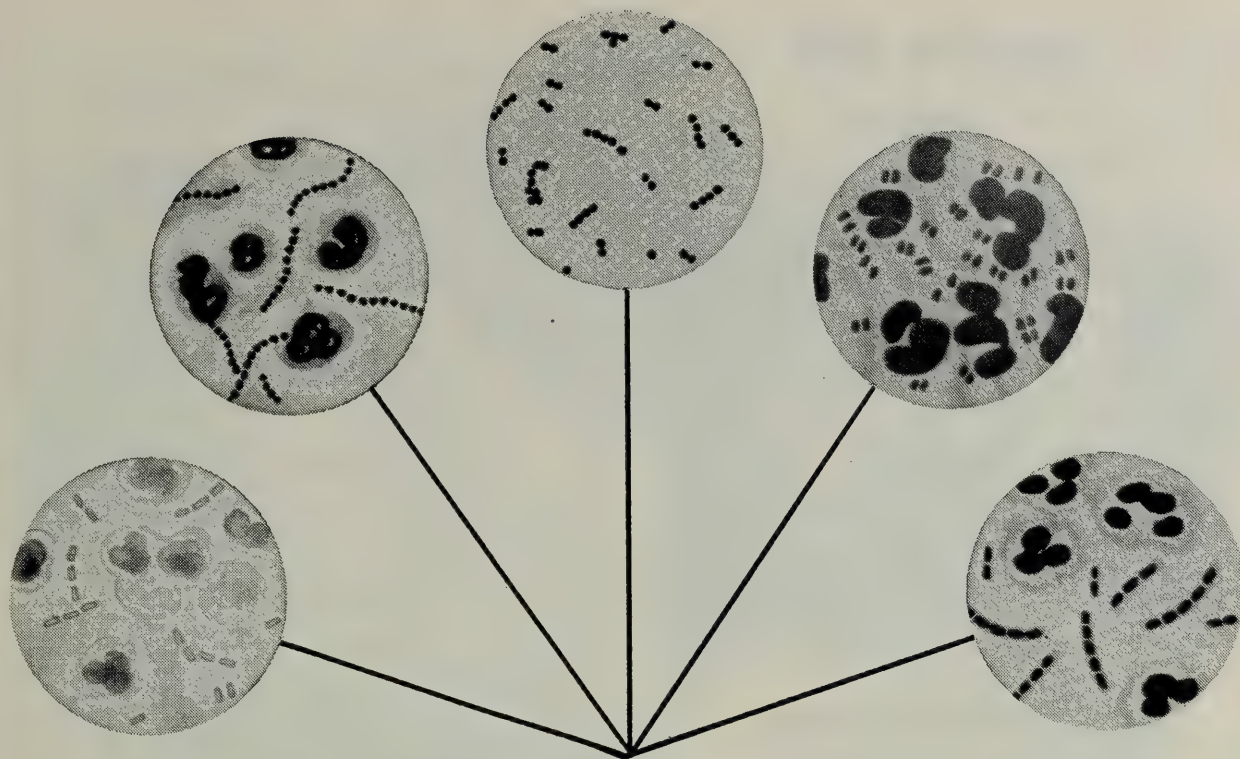
Everett B. Williams, Chicago, who graduated at Northwestern University Medical School in 1906, died March 17, aged 73. He was a member of the Illinois State Medical Society and of the staff of Ravenswood Hospital.

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## SPRUE OR ALLERGY?

It is unwise to draw conclusions concerning the value of a drug or procedure in the treatment of a chronic disease, from observations on a single patient. This is especially true when the disease is characterized by unpredictable remissions and exacerbations. Nevertheless, the rapid and dramatic improvement in this patient (sprue) after the institution of a wheat-free diet without supplemental therapy strongly suggests that the remission was induced rather than spontaneous. Furthermore, the patient insisted that this particular remission was unlike any previously experienced, in that it was more complete. A similar response in a patient with sprue reported by McIver lends additional support to the con-

clusions that the wheat-free diet was the responsible factor. The change in the radiologic appearance of the small bowel after institution of the wheat-free diet was astonishing. In our experience and in that of others, the small bowel pattern rarely returns to normal during remissions, whether induced or spontaneous. In this patient, on the contrary, the pattern reverted entirely to normal within three months of the beginning of the treatment. (The radiologic study of the small bowel both before and after treatment was performed with a barium sulfate water mixture). *Julian M. Ruffin, M.D., et al, WHEAT-FREE DIET IN THE TREATMENT OF SPRUE. New England J. Med., Feb 18, 1954.*



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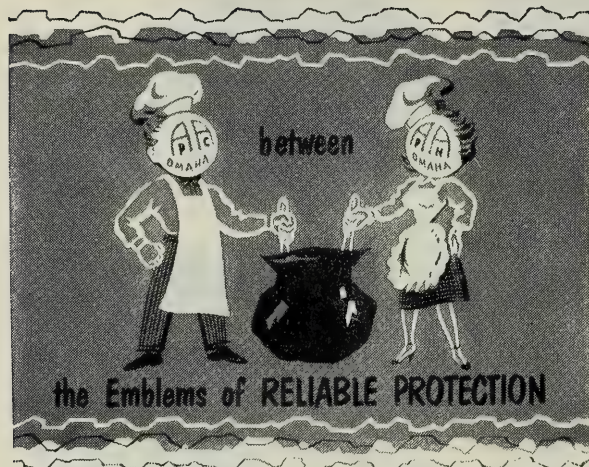
Each teaspoonful (5 cc.) of Suspension and each Tablet contains 150,000 units BICILLIN and 0.167 Gm. each of sulfadiazine, sulfamerazine and sulfamethazine.

1. Kolmer, J. A., and Rule, A. M.: Am. J. Med. Sc. 215:136-148 (Feb.) 1948
2. Lehr, D.: Antibiot. & Chem. 3:89 (Jan.) 1953



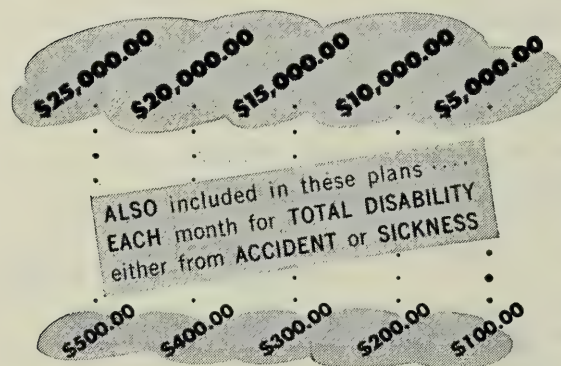
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## SOME ROENTGEN ASPECTS OF LUNG CANCER

**Harold L. Shinall, M.D., and George E. Irwin, Jr., M.D.  
Bloomington**

The increase in incidence of cancer of the lung and the obvious progress in the thoracic surgical techniques have made the early diagnosis of this condition more significant than ever. It is obvious that a diagnosis cannot be established until the patient presents himself for examination. Therefore, the continued education of the public is the first step in order that all may be alerted by the persistence of certain chest symptoms. The chest roentgenogram remains the single most useful method in diagnosis of carcinoma of the lung.

Although the conventional posteroanterior film of the chest may be decisive in some instances, it should be emphasized that other special projections and fluoroscopy should be utilized in the presence of suggestive symptoms in those instances when the posteroanterior projection is negative.

The roentgen manifestations of carcinoma of the lung are manifold and are dependent to some extent on the location of the lesion. The central lesion in a major bronchus may first be evident by virtue of the production of a valve type mechanism which permits ingress of air into the involved segment, but obstructs the outflow of air from this segment, thereby producing a segmental emphysema. This may be revealed by the presence of a zone of increased radiability or it may be detected only by the making of films in inspiration and expiration, in this way demonstrating a depression of the diaphragm on the involved side, which follows the trapping of air. Later, as the lesion grows, the obstruction becomes complete and obstructive atelectasis occurs. Properly exposed films in many projections may be necessary to observe the collapsed segment unless it is quite large. Associated secondary signs of atelectasis such as mediastinal shift and diaphragmatic elevation frequently give a clue as to the nature of the pathological process.

At times the lesion may be evident on the films only because of associated hilar adenopathy. Visualization of the tumor itself is unusual in these central tumors, except as a late manifesta-

(Continued on page 40)



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## LUNG CANCER (Continued)

tion. A unilateral somewhat rounded shadow, usually in the hilar region, coupled with certain features of the clinical history, is of great importance in the diagnosis of uncomplicated lung cancer. These clinical facts as previously reported by one of us<sup>1</sup> are: (1) Age of patient—usually over forty years, (2) duration of illness, often three months or more, (3) cough, usually dry and non-productive or none at all, (4) expectoration of blood, usually present at some time during the illness, (5) loss of weight, and (6) lack of fever or signs of infection. Obviously the lack of uniformity of symptoms increases the problem of diagnosis. The finding of the above listed features with definite roentgen findings of a tumor already indicates the presence of well-established disease.

The peripheral pulmonary neoplasms present even more difficulties from the standpoint of diagnosis. These frequently present themselves as rounded masses of varying size and in a peripheral location their differentiation into benign and malignant neoplasms on the basis of roentgen evidence becomes almost impossible. Various features such as the regularity of outline, the relative density, and the lack of calcification are useful diagnostic aids, but the lesion which is not calcified calls for prompt surgical consultation. Even in the presence of calcification, a pulmonary lesion cannot be unequivocally regarded as benign, although Good<sup>2</sup> has concluded that it represents the only sign of benignancy which can be relied upon with reasonable assurance.

This latter group of lesions becomes especially difficult to evaluate because of the relative paucity or complete absence of symptoms. In any discussion of symptomatology one should not neglect the frequent presentation of these lesions as an inflammatory process resulting from inadequate drainage from the partially obstructed segment. These inflammatory lesions respond nicely to medical management only to recur. Only rarely does the appearance of the chest revert entirely to normal after such an episode, and for that reason, every case of pneumonitis in an individual in the age group where neoplasm is likely to occur should be followed by progress films to demonstrate the prompt and complete clearing of the disease. If prompt clearing does

not occur, bronchoscopy should be done. The time wasted in repetitious filming is precious.

More and more of these lesions will be seen as time passes and as routine chest films are used more widely. It will then be the responsibility of the radiologist to recognize these lesions and to emphasize the need for prompt evaluation. From that point on the family physician must take over and see that the patient avail, himself of the opportunity for cure which can now be offered to the individual whose carcinoma is diagnosed early.

1. H. L. Shinall, M. D.: "Roentgen Diagnosis of Bronchiogenic Carcinoma", *RADIOLOGY*, Vol. 42, No. 3, Pages 213-219, March, 1944
2. C. Allen Good, M. D., Robert T. Hood, Jr., M. D., and John R. McDonald, M.D.: "Significance of a Solitary Mass in the Lung", *AMERICAN JOURNAL OF ROENTGENOLOGY, RADIUM THERAPY and NUCLEAR MEDICINE*: Pages 543-554, 70, October, 1953.

---

The newly reported active and probably active tuberculosis cases per 100,000 population varied among the States from a high of 164.0 for Arizona to a low of 16.4 for Nebraska (in 1952).

---

## ARE WE SLIPPING?

This public dissatisfaction with our craft is not new. Permit me another question: "Medicine is the most distinguished of all the arts but through the ignorance of those who practice it, and of those who casually judge such practitioners, it is now of all the arts least esteemed. The chief reason for this error seems to be this: Medicine is the only art which our states have made subject to no penalty save that of dishonor, and dishonor does not wound those who are compacted of it." This modern sounding comment was written more than 2,300 years ago and is ascribed to that Greek physician, Hippocrates, to whose oath most of us subscribed when we became doctors of medicine. In this same writing, "Law," he outlined the requirements of a practitioner of the art, naming natural ability, place of instruction, instruction from childhood, diligence, and Time. Like wine and cheese, a good doctor takes time in the making. *Alfred L. Potter, M.D., Medical Public Relations. Rhode Island M.J., Feb. 1954.*

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Niacin—5 milligrams  
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## COMBINED ANTIMICROBIAL THERAPY

It is frequent practice in the treatment of infections to employ antibiotics in "shotgun" fashion. This practice has been furthered by the recognition that in certain instances a definite synergistic action, or additive effect, is obtainable from certain combinations: tuberculosis (streptomycin plus PAS), brucellosis (streptomycin plus aureomycin), enterococcic endocarditis (penicillin plus streptomycin); bacterial meningitis—staphylococcic, pneumococcic, and streptococcic (penicillin plus sulfonamides), and Hemophilus influenza (streptomycin plus sulfonamides). In peritonitis and mixed bacterial wound infections, penicillin and streptomycin have been effective, although the broader-spectrum antibiotics seem equally as effective. Despite these examples there are experimental and clinical studies which show that certain combinations result in antagonism and diminished effectiveness. Aureomycin, Terramycin, and chloramphenicol have been shown to diminish the effectiveness of penicillin. The interference is apparently due to the inhibition of multiplication of organisms produced by the

bacteriostatic action of the broad-spectrum antibiotics; the bactericidal action of penicillin is manifested only with rapidly multiplying organisms, and hence penicillin activity is impaired by the concomitant use of these bacteriostatic agents. *Harrison F. Flippin, M.D., Philadelphia, Pa., Antibiotic Syndromes. N. Y. State J. M., December 15, 1953.*

It is well known that hookworm disease, malaria, and tuberculosis are intimately related to malnutrition in many persons who suffer from these diseases, but whether or not the relationship is causal defies affirmation except in certain individual situations. The sufferer of malaria or hookworm disease may be malnourished because of anemia that reduces his productive and earning capacity and therefore his ability to provide for his food needs. Or the malnourished person, as a result of diminished resistance, may fall an easy victim to such diseases. Whatever may be the relationship, it is clear that the well-being of the individual is compromised by malnutrition as well as by certain specific diseases. Institute of Inter-American Affairs, Pub. Health Reports, Nov., 1953.

## "A program of treatment for *chronic ulcerative colitis*...

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1. Rev. Gastroenterology 20:744 (Oct.) 1953; abstract in J. A. M. A., 153:1580 (Dec. 26) 1953.



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## BOOK REVIEWS



DISEASES OF WOMEN by Robert J. Crossen, A.B., M.D., F.A.C.S., Tenth Edition, Published October 1953. The C. V. Mosley Co., St. Louis. 935 pages, 990 illustrations. (41 in color.) \$18.50.

"The endeavor here has been to present for the student the basic facts and salient developments of the biologic and physiologic investigations which are making history in the gynecologic field." The purpose has been also "to bring to the practitioner a comprehensive, systematic, judicial consideration of the diagnostic and therapeutic aids made possible by these great advances in knowledge." Such is one of the early paragraphs used by the author in the "preface" in this book. Quite a monumental task. How well the work accomplished this is debatable.

This is not the outstanding volume that the earlier editions exhibited. But perhaps the impact of this volume is lessened by the fact that today there are many other productions of somewhat similar style and presentation produced since the earlier edition, and consequently one is not "startled" by clarity of text and illustrations.

Of course, many chapters in this 10th edition are new or are rewritten; such for instance is the use of the vaginal smear in the detection of

carcinoma, the physical changes occurring at the age of puberty, the changes in therapy and other subjects, the newer aspects of which are self evident.

The small portion dealing with the determination of the diagnosis of the conditions in the pelvis is excellent. Pitfalls are detailed and the matter of bimanual examinations is most lucidly handled.

As has been true in earlier editions, even the first, the dissertation concerning injuries to the perineum occurring as a result of labor and delivery is most elegantly dealt with. The diagrams, and reproductions of photographs are most clear and also portray artistic exactness in anatomy, and as to the effect of "tears" and as to the technique of repair, even in minute detail. The work deals with the varied types of fistulae involving the genital tract and most admirably also. One can recommend to physicians dealing with a case that is inoperable because perhaps of Ca, the perusal of that section mentioning means and ingenious devices for making the patient more comfortable, in spite of perhaps constant seepage, one can recommend this work as a guide for help. In this, as elsewhere, the editor does not fail to credit other physicians for their contributions on this subject.

*(Continued on page 51)*

## BOOK REVIEWS (Continued)

There is also of course a study of the vexatious problem of sterility. To this in a general manner has been given a rather well rounded consideration, with enough specific suggestions to enable one to approach and scientifically deal with the problem.

A short resume sets forth a great deal of information concerning medico legal points in gynecology.

This edition is replete with references as to source materials and these are listed at the close of the various chapters.

The book is quite an addition to the gynecological section of one's library and certainly one easily used as a reference work.

C. P. B.

**SURGICAL FORUM** — Proceedings of the Forum Sessions, Thirty-Eighth Clinical Congress of the American College of Surgeons, New York City — September, 1952. Surgical Forum Committee. 716 pages, illustrated. Philadelphia and London: W. B. Saunders Company, 1953. Price \$10.00.

The surgical forum of the American College of Surgeons was inaugurated some years ago, because of the vision and foresight of Owen H. Wangensteen, M.D. Today it is a medium by which studies dealing with surgical subjects in the laboratories may be presented. Many advances in the whole realm of surgery are the result of the intensive research conducted in the laboratory. The purpose, then, of this volume is to present the current results of this laboratory approach.

This is a collection of "papers" summing up the conclusion of research work in basic medical sciences as related to surgery. The content of these "papers" deals with many diversities, such as biochemistry, biophysics, physiology, physics, preoperative studies with post operative studies, nutritional and metabolic factors, techniques, etc., etc.

The extent to which the actual knowledge obtained in such work as this collection of "papers", the extent to which this is applied to better understanding of surgical disease will determine the extent to which surgery advances.

The greater number of these "papers" are very

(Continued on page 52)

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## BOOK REVIEWS (Continued)

interesting; the volume in no way lessens the well earned acclaim of the preceding volumes.

C. P. B.

**MAYO CLINIC DIET MANUAL** Second Edition by The Committee on Dietetics of the Mayo Clinic, Published by W. B. Saunders Company Philadelphia, London, 1954. Library of Congress Catalog Card Number: 54-5323 Copyright 1954. Price \$5.50

The first edition of this valuable manual was published in 1949. This represents the first revision. Naturally some changes have been made commensurate with the developments in the science of nutrition.

However, the general composition and structure of the manual has remained. It is well printed. The type and charts make for easy reading. There is a satisfactory index. The plastic ring binding may not withstand long hard usage.

J. W. P.

**ROSE AND CARLESS' MANUAL OF SURGERY FOR**

**STUDENTS AND PRACTITIONERS** by Sir Cecil Wakeley, B.T., K.B.E., C.B., L.L.D., M. Ch., D. Sc., F.R.C.S., F.R.S.E., F.R.S.A., F.A.C.S., F.R.A.C.S. Fellow of King's College, London & President of the Royal College of Surgeons of England. Assisted by 18 contributors. 1471 pages with more than one thousand illustrations.

The Williams & Wilkins Company, Baltimore, (printed in Great Britain). \$12.00.

The Rose & Carless Manual of Surgery has for a good many years been a standard of high rank in medical libraries. This new edition, the 18th, will maintain the reputation of its predecessors. There have been, at intervals, fifteen reprintings of several of the former editions and at least three editions have been translated into languages other than English. Nine years have elapsed since the 17th edition was published. The first edition appeared in 1898.

This Eighteenth edition has been to a great extent rewritten and presents many entirely new chapters, bringing the contents up to date

(Continued on page 54)

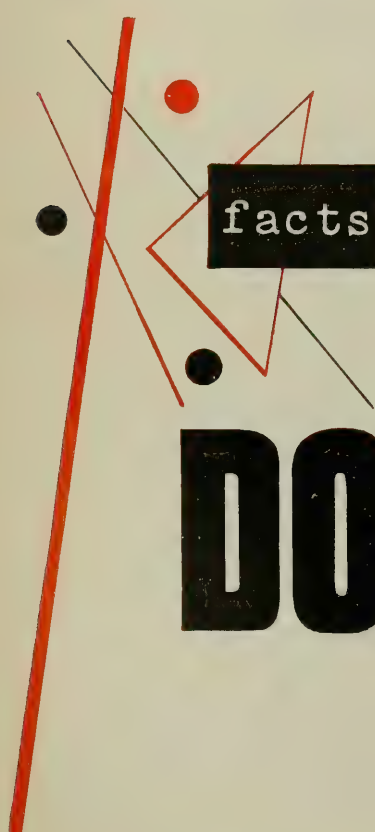
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- O'Brien, G. F. & Schweitzer, I. L.: The Med. Clinics of North America, W. B. Saunders, 1953, p. 163.
- Gauss, H.: Am. Jrl. Dig. Dis. 10:141 (1943)



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## BOOK REVIEWS (Continued)

with the more recent advancements in the various fields of surgery.

The Editor, Sir Cecil Wakeley, recognizing the enormous volume of work in the production of a manual of surgery, has "called upon" eighteen other well qualified contributors to help out in various branches.

One of the many new additions found in this edition is concerned with biopsy in surgery. Seldom does one find more clearly expressed the indication for biopsy, the theory and the practical use of it. The same is true for that portion dealing with orthopedics. This portion is quite general and yet specific. It contains about all the information a general practitioner might need in dealing with his problems on bones and joints.

Ample space is devoted to the newer aspects of the practice of surgery: Examples of this are the chapters on "Water & Salt Deficiency in Surgery"; "Biopsy in Surgery"; "Chemotherapy"; "Disorders of the Blood"; "Blood

(Continued on page 56)

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## BOOK REVIEWS (Continued)

Transfusion"; "Hemorrhage and Shock"; "The Use of Physical Agents in Surgery"; "The Pathogenesis of Infection"; "Burns and Their Treatment"; and "Plastic Surgery." Another important advance considered is that of thyroid disease and the use of radioactive iodine.

The book, as it has been in the past, is large, however, it is well bound. The type is quite easy to read, and the arrangement is excellent. The index is adequate.

C. P. B.

### BOOKS RECEIVED

The following books have been received for reviewing, and are herewith acknowledged. This listing should be considered as a sufficient return for the courtesy of the sender. Books that appear to be of unusual interest will be reviewed as space permits each month. Readers desiring additional information relative to books listed, may write the Editor who will gladly furnish same promptly.

**MAYO CLINIC DIET MANUAL:** By the Committee on Dietetics of the Mayo Clinic. New, Second Edition. 247 pages. Philadelphia and London: W. B. Saunders Company, 1954. Price \$5.50.

**CURRENT THERAPY 1954** — Latest approved Methods of Treatment for the Practicing Physician: Editor: Howard F. Conn, M. D., Consulting Editors: M. Edward Davis; Vincent J. Derbes; Garfield G. Duncan; Hugh J. Jewett; William J. Kerr; Perrin H. Long; H. Houston Merritt; Paul A. O'Leary; Walter L. Walmer; Hobart A. Reimann; Cyrus C. Sturgis; Robert H. Williams. 898 pages. Philadelphia and London; W. B. Saunders Company, 1954. Price \$11.00.

**MANUAL OF CLINICAL MYCOLOGY:** By Norman F. Conant, Ph. D., Professor of Mycology and Associate Professor of Bacteriology, Duke University School of Medicine. David Tillerson Smith, M. D., Professor of Bacteriology and Associate Professor of Medicine, Duke University School of Medicine. Roger Denio Baker, M. D., Chief Laboratory Service, Veterans Administration Hospital, Durham, N. C. Jasper Lamar Callaway, M. D., Professor of Dermatology and Syphilology, Duke University. Donald Stover Martin, M. D., Chief, Bacteriology Section Communicable Disease Center, Chamblee, Georgia. New School Edition. 456 pages with 202 figures Philadelphia and London; W. B. Saunders Company, 1954. Price \$6.50.

(Continued on page 58)

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## BOOKS RECEIVED (Continued)

**ENERGY METABOLISM AND NUTRITION.** By Professor Raymond W. Swift and Professor Cyrus E. French, Department of Animal Nutrition, The Pennsylvania State University. The Scarecrow Press, Washington, D. C., 1954. \$5.75.

**LECTURES ON THE THYROID.** By J. H. Means, M. D., Jackson Professor of Clinical Medicine Emeritus Harvard University, Former Chief of Medical Services, Massachusetts General Hospital, Physician, Massachusetts Institute of Technology. Harvard University Press, Cambridge, 1954. \$3.00.

**THOUGHTS ABOUT LIFE.** By Felix Friedberg. Philosophical Library, New York, \$2.50.

**THE DYNAMICS OF VIRUS AND RICKETTSIAL INFECTIONS.** Editors: Frank W. Hartman, M. D., Frank L. Horsfall, Jr., M. D. and John G. Kidd, M. D. The Blakiston Company, Inc. \$7.50.

**GERIATRIC MEDICINE.** Medical Care of Later Maturity. Edited by Edward J. Stieglitz, M. S., M. D., F. A. C. P. Third Edition. 205 figures. J. B. Lippincott Company, Philadelphia, London, Montreal. \$15.00.

**A DOCTOR TALKS TO WOMEN:** By Samuel Raynor Meaker, M.D., Boston, Massachusetts. Publication date April 5, 1954; Simon and Schuster, New York-1954. Price \$3.95.

**ANATOMY FOR SURGEONS:** Volume I; The Head and

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Neck, by W. Henry Hollinshead, Ph.D., Professor of Anatomy, Mayo Foundation, University of Minnesota Head of the Section of Anatomy, Mayo Clinic, Rochester, Minnesota. 326 illustrations, 560 pages; new. A Hoeber-Harper Book, Paul B. Hoeber Inc. 49 East 33rd Street, New York City. Price \$12.00.

**DISEASES OF THE LIVER:** By Mitchell A. Spellberg, M.D., F.A.C.P., Association Professor of Clinical Medicine, University of Illinois School of Medicine; Associate Attending Physician, Department of Medicine, Michael Reese Hospital, Chicago. Published by Grune and Stratton, New York, 1954; Price \$16.50.

**PEDIATRIC PROBLEMS IN CLINICAL PRACTICE:** By H. Michal-Smith, Ph.D., Chief Clinical Psychologist Flower and Fifth Avenue Hospitals, Research Associate in Pediatrics, New York Medical College, New York City. Published by Grune and Stratton, New York, 1954. Price \$5.50.

The undetected case of tuberculosis in a mental hospital is a menace to everyone in the community. The patients in the hospital, the employees, the visitors, and the families to whom the patients return are all subject to infection from the unknown case. Elizabeth S. Kletzsch, NTA Bulletin, Feb., 1954.

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## STREPTOMYCIN AND DIHYDRO-STREPTOMYCIN

*Editorial, The New England Journal of Medicine, June 18, 1953. (Reprinted with slight revision by the author.)*

In 1946 it was reported that streptomycin salts may be reduced to form corresponding dihydrostreptomycin salts; which were more stable in alkaline solution and had other desirable chemical properties. Subsequent reports on the comparative activity of streptomycin and dihydrostreptomycin, both *in vitro* and *in vivo*, showed that on the whole the drugs were equally active, although against a number of bacterial species, including some strains of tubercle bacilli and of salmonella, dihydrostreptomycin was appreciably less active.

In the November, 1948 issue of the *American Review of Tuberculosis* a series of six separate reports on laboratory and clinical aspects of dihydrostreptomycin appeared. Among them were two clinical reports, one on 14 patients treated at the Mayo Clinic and the other concerning 12 patients observed at the New York Hospital. The investigators in both clinics concluded that

dihydrostreptomycin seemed to be as effective as streptomycin and had the advantage of being tolerated longer before toxic manifestations became apparent. The other important feature noted was the fact the dihydrostreptomycin could be used to continue therapy in some patients who had shown sensitivity reactions to streptomycin. Although these workers were satisfied that dihydrostreptomycin was an improvement over streptomycin in this regard, both groups emphasized the fact that its administration in sufficiently large doses could produce the same damage to the nervous system as streptomycin. A major drawback to large-scale use of streptomycin is the emergence of drug-resistant strains of tubercle bacilli and this was not overcome by the derivative; moreover, cross-resistance between the two agents was complete.

In spite of the small number of cases and the short period of the study, these observations, had such a profound effect on many tuberculosis clinics and general hospitals that they rapidly turned from streptomycin to the use of dihydrostreptomycin. Within a short time nearly 90 per

*(Continued on page 62)*

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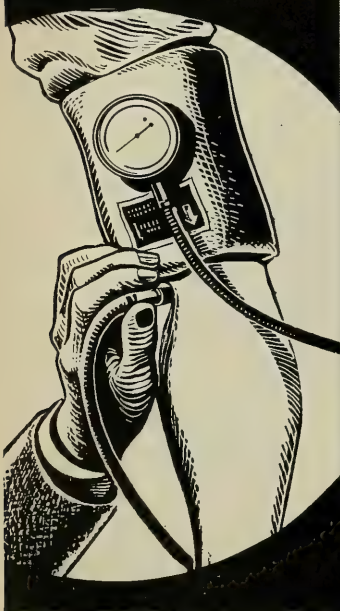
\*Alexander, R. M. and Manheim, S. D., *J. Invest. Dermat.* 21: 223-225, October 1953.

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## STREPTOMYCIN (Continued)

cent of all streptomycin that was produced and distributed was in the form of salts of dihydrostreptomycin.

It was not long, however, before workers began to realize that dihydrostreptomycin was not as innocuous as the early reports had led them to expect; indeed, that its potential toxicity was fully as grave as that of streptomycin. Although the toxic effects of dihydrostreptomycin on the vestibular apparatus were less than those of streptomycin, severe damage to the auditory nerve with permanent loss of hearing and even complete deafness were far more frequent, particularly when intensive and prolonged therapy was employed. These complications led several observers to recommend that dihydrostreptomycin be used only with patients who had become sensitized to streptomycin.

A more controlled study of the comparative toxicity and efficacy of the two forms of streptomycin was made by the workers in the hospitals collaborating with the Veterans Administration's study on the chemotherapy of tuberculosis. Data in groups of patients treated in exactly the same manner but given either streptomycin or dihydrostreptomycin, the choice of agent being entirely by a random selection, were presented at the Eleventh Conference of Chemotherapy of Tuberculosis in January, 1952. The study indicated that dihydrostreptomycin and streptomycin were equally effective and equally toxic, but whereas streptomycin was somewhat more toxic to the vestibular apparatus, dihydrostreptomycin caused more auditory damage and perhaps slightly fewer hypersensitivity reactions.

At the 12th Conference, in February 1953, Lyght and Hawkins reported on another controlled study of the efficacy and toxicity of these two agents. They found both to be about equally effective. Streptomycin apparently produced a higher percentage of sputum conversions, caused more allergic reaction, and frequently was significantly toxic for the vestibular system. Dihydrostreptomycin was relatively well tolerated with respect to allergic reactions, seldom was toxic for the vestibular system but was more likely to cause auditory loss which was sometimes progressive, especially after prolonged therapy.

Two other studies dealing with the combined use of streptomycin and dihydrostreptomycin,  
(Continued on page 64)

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## **STREPTOMYCIN (Continued)**

were reported at this conference. A laboratory study, by Poutsika, Thomas Linegar and Hobson, dealt with ataxia in cats — a delicate test for vestibular function. These tests showed that the time required for ataxia to develop in the cat from either streptomycin or dihydrostreptomycin was inversely related to the dose and that with the same dose it took appreciably longer to demonstrate ataxia with dihydrostreptomycin. When a similar total amount was used as a 1:1 mixture of the two agents, the appearance of ataxia was somewhat delayed over the time required for it to appear when streptomycin alone was used. This finding seemed important enough to warrant clinical trial of the mixture.

Such a clinical trial was reported by Heck and Hinshaw in 110 patients, each of whom was given daily doses of 1 gm. for 120 days; 34 received streptomycin, 34 dihydrostreptomycin, and 42 the 1:1 mixture of the two agents. Vestibular and auditory damage was studied during a six months' follow-up period. Vestibular disturbances were noted in six (18 per cent) of patients treated with streptomycin and in two (6 per cent) of those receiving dihydrostreptomycin; auditory disturbances were noted in none of the former, and in five (15 per cent) of the latter. All of the 42 patients treated with the 1:1 mixture were free of both vestibular and auditory disturbances.

Although this clinical demonstration appears to be quite striking, it would seem wise to accept the conclusions with caution. The number of patients was not large, and the results, judging from the laboratory experiment, appear to have been inordinately favorable. Further observations in large numbers of cases are necessary to be obtained regularly, and under different treatment to ascertain whether equally favorable results can be obtained with different regimens.

In spite of the recent introduction of isoniazid and the demonstration of its effectiveness, streptomycin, either as such or as dihydrostreptomycin is still the mainstay of long-term anti-tuberculosis therapy. Perhaps the most critical situation in which the availability of two forms of streptomycin has proved useful is in patients who have become sensitized to one of these

(Continued on page 66)



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### STREPTOMYCIN (Continued)

agents. In such patients it has been possible to give the alternate compound without serious reactions and thus permit prolonged therapy. The hazard of sensitizing patients to both agents must be seriously considered and weighed.

Daily doses of streptomycin were used in the reported studies, perhaps in order to obtain comparable effects. Such doses are no longer considered necessary or desirable except possibly for short periods when chemotherapy is being instituted in acutely ill patients or in preparation for surgery. The most desirable and acceptable regimen for long-term therapy, employs streptomycin twice a week with para aminosalicylic acid daily. With this regimen the incidence of both vestibular and auditory disturbances from either form of streptomycin is low. This removes another cause for seeking to confuse chemotherapy by the use of the combined agents, each of which has certain distinct properties that it may be desirable to invoke separately in critical situations.

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Health education is an aspect of all education and is a life-long process. James Mackintosh, Prof., European Conference on Health Education of the Public, London, England, April 10-18, 1953.

## LOUDER!

Most modern medical meetings of more than 20 or 30 persons are held in halls where public address systems are installed. If properly installed, the system has no doubt been adjusted to the acoustics of the hall, but this is not always the case. Nevertheless, every speaker except perhaps the presiding officer who first calls the meeting to order has not only the opportunity but the duty to himself and his audience, to listen and in a few seconds to learn whether that particular hall has good, bad, or indifferent acoustics; whether there are appreciable echoes or sound reflections that effectively slur one word into the next without giving the impression of a full echo. If so, he should instantly decide to go a little slow, to emphasize his enunciation, and allow that split-second pause between short phrases and groups of words that permits reflections and echoes to die before the next phrase comes out. Believe us, it's not difficult. It takes only determination to speak well, a very little practice, a few seconds of listening and observing the preceding speaker, to know how far to speak from that particular microphone or how loud to speak if there is no public address system. It goes without saying that the Arrangement Committee for the meeting should see that the public address system is operating properly, and nine out of 10 such systems should be monitored during the meeting by someone who understands their eccentricities and who really knows which dial controls the volume. *Editorial, Let's Learn To Use Those Microphones. Rocky Mountain M.J. Sept. 1953.*

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Insane persons are sick persons. Long before institutional care is arranged, these lunatics ordinarily are observed professionally by the family physician or the psychiatrist in private practice. Deep resentment and hostility often arise so that every physician at any time might become the victim of violence at their hands. Dr. Edward Spalding, Detroit's distinguished cardiologist, consultant to industry, and sponsor of good industrial medicine, was slain by a madman. Dr. Spalding never saw his assailant; never was he the doctor's patient. The distorted mind mistook him for one of 11 victims marked for retaliation because of imagined wrongs. Far earlier, this lunatic had been under institutional observation for mental aberrancy. There is every willingness to recognize that mental hospital beds are all too few. There may be good reason to discharge from a hospital those who apparently have attained some degree of stability in order that more violent ones may be accepted as a safeguard for the public. The limitations that necessarily attend the diagnosis of mental

disorders fully are respected. Still, withal, is it too much to hope that the day will come when better psychiatry will be able to predict with fair certainty the future behavior of mental deviates, once they have been under institutional scrutiny? Dr. Edward Spalding is dead; his usefulness is over — his good mind and body destroyed by a wasted and useless mind. There is small comfort for anyone in the madman's foolish statement, "I must have killed the wrong man." *Editorial, A Threat to Physicians. Indust. Med., Jan. 1954.*

## VIOMYCIN IN TUBERCULOSIS

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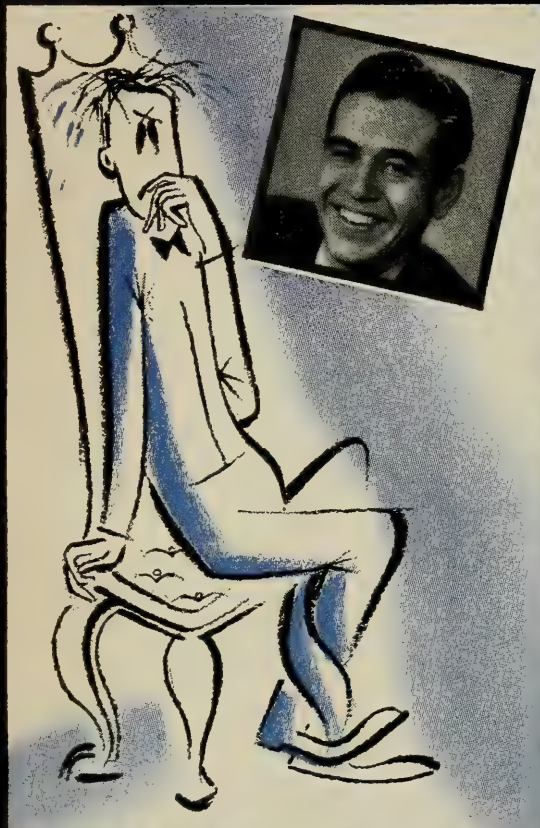
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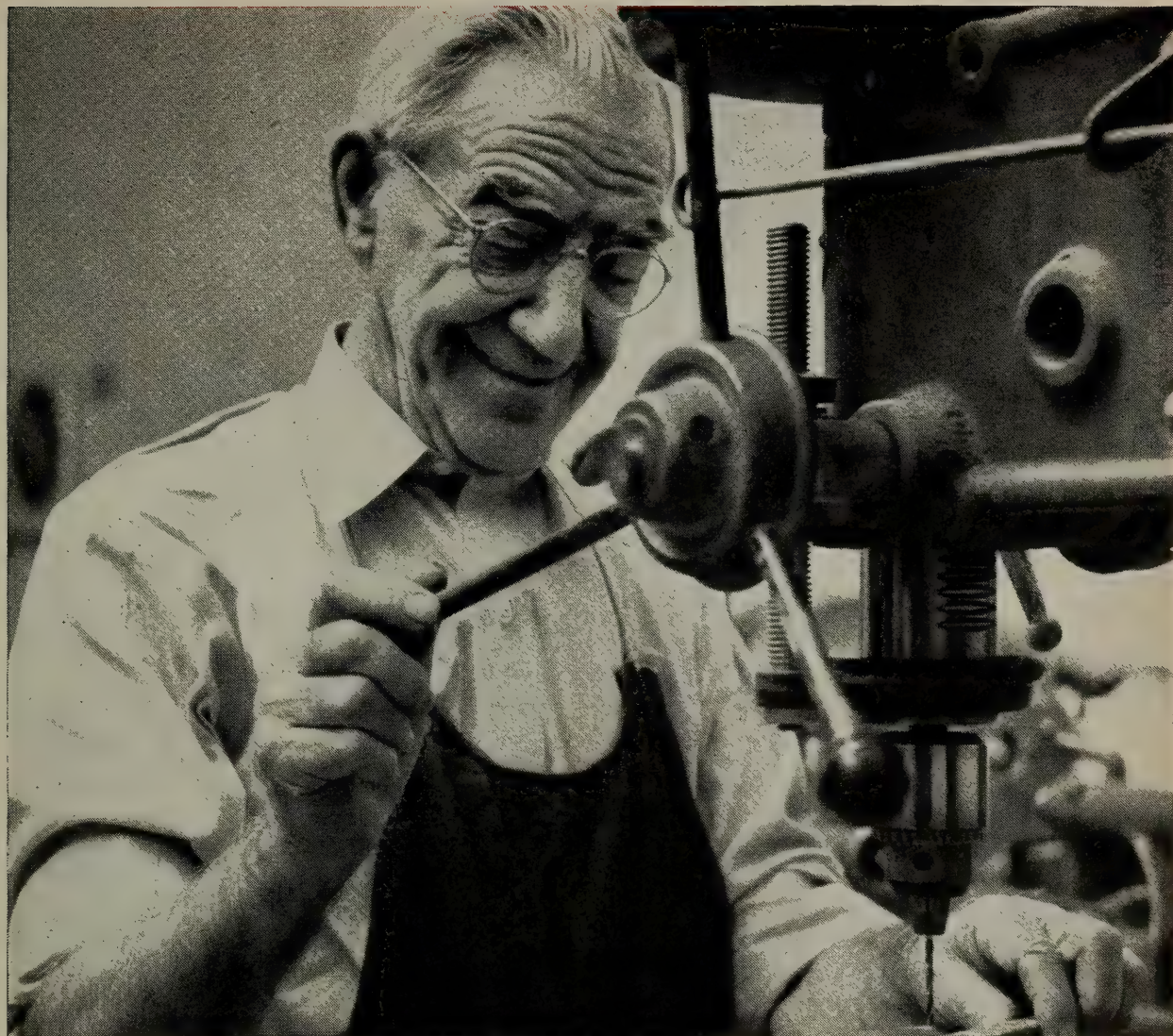
## PUBLIC INTEREST IN MENTAL HEALTH

The chaotic condition of modern life has raised public interest in mental health to an unprecedented level. Lecturers on mental health problems speak to overflow audiences, and mental health clinics are swamped by the vast number of those seeking psychiatric services. The medical profession as a co-operating group has with greater or lesser success organized and planned attacks on physical disease, but there is a woeful lack of understanding that the problems of mental health are fully as enormous in their complexity as is the whole field of physical health.

It has been estimated that half of the hospital beds in the United States are occupied by victims of mental illness. This ominously large number of patients is only a small percentage of the population whose mental illnesses cause such havoc in the social life of the community. Dr. Martha Eliot, Chief of the Children's Bureau, estimated in July, 1952, that there are committed each year 1,750,000 serious crimes and that 1,500,000 children between the ages of 7 and 17 are picked up by the police and 350,000 brought to juvenile courts. There are 50,000 narcotic addicts and 950,000 confirmed chronic alcoholics. There are about 17,000 suicides each year and one divorce in every four marriages. This is an ominous picture of emotional illness. *Editorial, The Family Doctor and Mental Health Programs. M. Ann. District of Columbia, June 1953.*

Few of us realize that tuberculosis is both a cause and an effect of indigency. It is simple to grasp the fact that poverty lowers resistance so that the disease spreads rapidly when families live on an inadequate or unbalanced diet, are crowded into insanitary homes, can obtain little education. But we do not always stop to think how directly tuberculosis leads to poverty in families where it did not previously exist. A recent study of a sizable group of patients pointed out that less than two per cent of the patients' families were relief recipients at the time of diagnosis; upon being admitted to hospitals a few months later, 16 per cent of the families of these patients were on relief. Mary Dempsey, Statistical Unit, NTA, Feb. 3, 1954.

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There is much reason to believe that efforts aimed at increasing the general resistance of the body would contribute to progress, not only in the control of tuberculosis, but also in that of several other infectious diseases as well. It is a remarkable fact that the death rate of several bacterial respiratory infections follows a course parallel to that of tuberculosis. Rene J. Dubos, Ph.D., Am. Rev. Tuberc., July, 1953.

## ULTRASCIENTIFIC ALOOFNESS

A survey recently was made of community attitudes toward physicians, of what people expected of them, and how well they thought their needs were being met. A general feeling was expressed that doctors were usually too busy to listen and talk with their patients or to try to understand the emotional factors growing out of family, economic or sociologic stresses. All through these reports it was thought that the human side of medical practice had been increasingly sacrificed, that mechanism was crowding out spirit, the patient often being lost in the nexus of speed, organization, many appointments, business, measurement, organs, and reports. In the complexity of ultrainvestigativeness, the personality, the individuality, the feelings, the patient himself, for whom all this exists disappears. Ultrascientific aloofness and detachment, called objectivity, often appear to the patient as indifference, complacency, or even rejection as if his visit to the doctor were an unwelcome intrusion in a busy professional schedule. *Kenneth E. Appel, Putting The Family Back in Medical Education. New England J. Med. Sept. 3, 1953.*

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# *The* ILLINOIS *Medical Journal*

Official Journal of the Illinois State Medical Society

Harold M. Camp, EDITOR.

Theodore R. Van Dellen, ASSOCIATE EDITOR.

Vol. 105, No. 6

June, 1954

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## "Not by Works Alone"

Willis I. Lewis, M.D., F.A.C.S.

Herrin

President, Illinois State Medical Society

There are definite threats of encroachment on American medicine today as there have been for the past twenty odd years. We propose to explore these threats of encroachment in this discussion today.

As physicians we have been justly proud of our achievements. We have been proud to belong to an honored, dedicated profession. We have conquered disease after disease, making every age of man safer, and lengthening life expectancy. Our dedicated purpose and our achievements for the general good have in the past assured to us a place of respect in the community. We still hold that place in the cities and towns where we practice. But there is one place where our achievements and our high purpose are discounted and that is in the halls of Congress.

Most of you will remember the address made five years ago by our Past President, Dr. Percy E. Hopkins. He spoke on *The Challenge*. That was a few months after the election of President Truman in 1948. Some of us had hoped the New Deal would be thrown out at that time and that a more moderate, conservative administration would come in. Instead, the Fair Deal took over. Dr. Hopkins then warned that American Medicine saw itself "as the area in which Socialism seeks to establish a beachhead from which to spread its blight all over our nation and it determined to resist the invasion."

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Presidential address delivered at the 114th Annual Meeting of the Illinois State Medical Society, Chicago, May 19, 1954.

Five years have passed since those words were spoken. Two years ago, the Nation in a great landslide voted to turn out the New Deal-Fair Deal planners. There was a clear mandate to "drive the rescals out." American medicine came out wholeheartedly for an Administration that gave assurances of being against socialized medicine and compulsion. Eisenhower was elected. Two years ago the medical profession as a whole probably reflected the viewpoint of the doctor who said: "Now I can forget politics and get back to the practice of medicine."

But no sooner had the new Administration taken over in Washington in 1953 than the President announced he was creating a Department of Health, Education and Welfare. This was to be headed by a New Dealer from Texas. Many of us were dismayed. We remembered how we had fought repeated efforts by Oscar Ewing to have such a department set up. We had been fearful that a department of that type, in which welfare and social security would have most of the money and power, might hasten the movement to socialize medicine.

I need not here review the blitzkrieg measures employed to force through acceptance of the Health, Education and Welfare Department. In the end, the medical profession was not even accorded a medical under-secretaryship. We wound up with a figurehead representative of medicine in the role of Special Assistant for Health and Medical Affairs.

Now what has happened to the medical pro-

fession under this new Administration? On January 7, 1954, President Eisenhower in his State-of-the-Union message said: "I am flatly opposed to the socialization of medicine. The great need for hospital and medical services can best be met by the initiative of private plans. But it is unfortunately a fact that medical costs are rising and already impose severe hardships on many families. The Federal Government can do many helpful things and still avoid the socialization of medicine."

The first half of this statement was reassuring; the second half gave us concern as we wondered what the Federal proposals would be. Now we know. While a large number of bills have been introduced in the House and in the Senate to carry out this Administration's plans in the fields of health, education and welfare, the major proposals affecting our profession are three:

1. Inclusion of members of the medical profession under the Social Security taxing system, *compulsorily*;

2. Establishment of a Federal corporation to reinsure private health insurance companies and plans; and

3. Creation of a scheme whereby physicians would certify permanently and totally disabled persons and would be paid by the Federal Government from the Federal Old-Age and Survivors Insurance Trust Fund.

Let us look at this three-pronged attack on the medical profession. First, our inclusion in the Social Security system. Doctors as a group have said they do not wish to be compelled to enter this system. The American Medical Association and state and county medical societies have stood firm in their opposition to such compulsion. Why are we as a profession opposed to such inclusion in the Social Security system? There are many reasons, and I shall mention only a few. In the first place, we do not like to be *compelled* to buy Government protection for old age. We are individualists and like to make our own provisions for retirement through savings, investments, and otherwise.

Secondly, the fact has been brought out again and again at recent hearings on Social Security that no one is paying enough in Social Security taxes to pay for the relatively large benefits that are promised, the so-called "bargain annuities." It

will be 60 or 70 years before workers and self-employed persons will be paying large enough taxes to make the system sound and self-supporting. I feel quite certain that physicians do not want to seek benefits for which they have not paid and which, therefore, are a form of public charity.

Then there is a third important reason why the majority of doctors do not want to be forced into this system. The law says that a person at 65 cannot draw his benefits unless he has retired from his job or his business. Now I feel very certain that most doctors don't want to stop their professional activities at age 65. A doctor in later life may slow down a bit, do less night work, take longer vacations — in a word, be a bit kinder to himself. But he does not want to say: "I'm finished at 65." No, most doctors want to die with their boots on. But if they entered the Social Security system they would be forced to pay these special taxes of \$126.00 a year now — more later — and would derive no benefits unless they stopped practicing. It is true that if a doctor with young children were to die in middle life, his wife and children would be entitled to survivor benefits until each child reached the age of 18. And I may say that the Government is trying to induce doctors to accept the Social Security taxation by pointing to the "cheap" survivorship benefits. I hope no doctor will permit himself to be drawn into this purely Socialist Social Security system because he thinks he may get bargain benefits. I feel confident the medical profession wants to pay its own way in this world and does not wish to profit from the tax payments of other people.

Now let us look at the second proposal made by this Administration in the health field. This is the President's reinsurance plan. Hearings have been held in the House and in the Senate. The present plan is for the legislation to be enacted and put into force by July 1 of this year. This proposal calls for the creation of a new Federal corporation which would be set up in the insurance business with an initial grant of \$25 million from the general Treasury funds.

Under this scheme the Federal Government would cover a portion of the losses suffered by private insurance companies, Blue Cross plans, and Blue Shield plans if they were to underwrite

poor risks not now considered insurable. What the Government is trying to do is to stimulate private insurance carriers to insure the aged, the chronically ill, the so-called medically indigent, or low-income families, and other groups and individuals which now cannot obtain insurance or do not choose to seek it. The Government is trying to make insurers charge premiums which would not cover the costs of medical care for those substandard groups. Then, when losses were sustained, the Government would pay part of the loss.

Private insurance companies have said there is no need for this Federal reinsurance because the industry already has plenty of funds for reinsuring sound risks. However, Blue Cross and The American Hospital Association have expressed a willingness to go along with the Government and to accept the promised subsidy for poor risks. The prediction has been made, and I think it is accurate, that were this reinsurance plan set in motion, the original \$25 million subsidy would melt away in no time and the Federal Reinsurance Corporation would come back to Congress for more funds. Before long, the Federal Government would simply take over the private insurance of medical care costs and hospitalization and we would have compulsory health insurance.

Let me urge you at this point not to be fooled by soothing assurances that the Government opposes socialized medicine and is offering this reinsurance plan to protect our profession from Federal control. If you will look at the bills now before Congress you will see that the Secretary of Health, Education and Welfare is authorized to write the rules and regulations for the operation of this new Federal corporation. The Secretary, presently Mrs. Hobby, is to set the premium rates which insurance companies and nonprofit plans will have to pay for reinsurance. She is to say how such companies and plans are to conduct their insurance business. And I have no doubt at all that the rules and regulations will cover the fees to be paid to physicians and the rates to be charged by hospitals. I warn you this legislation is a great threat to our profession, to our hospitals, to our nonprofit plans, and to the American people.

If you think perhaps I am unduly alarmed, I would remind you of a Supreme Court de-

cision handed down in 1942 in connection with a farmer who planted a few acres more than Federal officials had told him he could plant. He was fined by the Government under the Agricultural Adjustment Act. Incensed, he carried his case all the way to the Supreme Court. But that Court upheld the lower courts in a ruling handed down by Associate Justice Jackson who said:

"It is hardly lack of due process for the Government to regulate that which it subsidizes."

Think of it! *The Government may regulate that which it subsidizes.* That is the threat which I see to the medical profession in the reinsurance plan and in the Social Security proposals. *Government regulation and control.* Indeed, every bill that I have seen authorizes the Federal official who is to administer the program to write the rules and regulations. Control and subsidy are the essence of State Socialism. *Control and subsidy!*

Now we come to the third legislative proposal being made in the health field by this Administration. It is the one which would bring doctors into the Social Security social insurance system as certifiers of disability. The proposal is attractively packaged so that we will be induced to buy it. We are told that the Federal Government feels it is unfair for a worker who has paid his Social Security taxes for years and who then becomes permanently and totally disabled to have his retirement benefits reduced by inclusion in his earnings record of maybe 10 or 15 years of nonearning. The Government, therefore, proposes to freeze the benefits at the amount the worker would be entitled to if he were 65, instead of 45 or 50 at the time he ceased working because of disability. But in order to determine that a worker is disabled and therefore entitled to this benefit freeze he will have to be certified by a physician.

That is where we come in. State Vocational Rehabilitation agencies or State Health or Welfare departments are to make agreements with State medical societies as to the terms on which doctors will agree to certify permanently and totally disabled workers. These arrangements will be hedged around by Federal Rules and regulations. Doctors are to be paid from the Old-Age and Survivors Insurance Trust Fund of the Social Security system. If they agree to any such arrangement, that would be the

first step to bringing all doctors into the compulsory Social Security scheme as practitioners under Federal Control.

This is the way I see things. Doctors would first be expected to certify persons permanently and totally disabled. They would be paid by the Federal Government according to a pre-arranged fee schedule. Next there would be pressure to have physicians give these disabled persons medical care so that they could be rehabilitated. Again the fees would come from the Old-Age and Survivors Trust Fund. And with the Federal fees would come Federal regulations.

Then, if we look at what has happened in other countries, there would be pressure from labor unions to have doctors certify persons who were sick for a *short* time. After that would come demand for medical care for *temporary* sickness, fees to be paid by the Social Security system. Step by step we would be carried along into a full-fledged scheme of national compulsory Social Security medicine.

If we take the first step — the permanently-and-totally-disabled certification step, then there is no doubt in my mind we will take all the other steps. Medicine will be nationalized here as it was in Great Britain. And I would fail you, as the President of this Society, if I did not warn that we are today being more dangerously threatened by the Federal Government than we have ever been. These legislative proposals of which I have spoken have been presented by this Administration as a means of *saving* us from socialized medicine, whereas actually they are the sure means of delivering us into Federal control.

If there is anyone in this room who is toying with the idea that perhaps socialized medicine would not be so bad and is at least worth a try, I would say to that person: "Go to Great Britain. There you can see socialized medicine in action." Great Britain, you will recall, embarked on this Socialist plan in 1911 when Lloyd George, an enthusiastic follower of Bismarck, persuaded the British Parliament to provide State medicine for British workers. At that time the *families* of workers were not included in the scheme. But for over 30 years some 40 per cent of the British people have known nothing better than panel practice and "bottle medicine." I do

not hesitate to say that the rank and file of people in Great Britain have no idea of what good medical care really is. They have been brought up on panel practice and have accepted it. In 1948, when the National Health Service became law, this panel practice was extended to the entire population.

Patients are rushed through doctors' surgeries at the rate of one every three minutes. They receive their prescription for a bottle of medicine, but no examination. Hospitals are jammed with patients seeking routine examinations which we would give in the office of a general practitioner in this country. A Socialist doctor, you should know, has no office equipment, no office nurse, no secretary. He is little better than a Government clerk, writing prescriptions for simple remedies and filling out stacks of Government forms.

That is the sort of thing that is in store for American physicians unless we are very alert and unless we let the Congress and the Administration know exactly what we think about these current Federal legislative proposals. We have fooled ourselves into believing that our good works would protect us. We have thought that by our research, our healing of the sick, our devotion, and our high purpose we would somehow convince the Government that we should be let alone to carry out our sacred mission as physicians. But politicians are not to be appeased by good works.

In all countries which have embraced Socialism or Communism, the medical profession has been one of the first to be taken over. Let us remember that. The Government now says to us: "You have done a wonderful job with voluntary insurance. But we want to move even faster. So we wish to take over the job and run private insurance." Again the Government says: "We know you do not wish to be forced into the Social Security system. But we want the money your taxes would furnish." Finally, the Government says: "We know you do not wish to embark on this Social-Security-controlled certification system for total and permanent disability claimants. But we insist you cooperate with us." This certificate scheme is the prime entering wedge for the nationalization of medicine.

With these and many other threats to the independence of medicine, we must, however reluctantly, prepare for the inevitable battle ahead. In all countries, governments have sought to control medicine. *This must not happen here.* In taking our stand, we must realize it is not enough to have given this country the finest medicine in the world. It is not enough to have developed research and training centers that are the envy of the world. It is not enough that we have more physicians, dentists, and nurses

per thousand of population than any other country in the world. It is not enough that we have the finest, fastest growing system of voluntary health insurance that the world has ever seen. No, our medical achievements are not enough to save us from political attempts to capture American medicine. We must devote part of our time to protecting our integrity, our freedom, and our professional independence so that these may forever be secure from regulation and control by the Government.

---

## Treatment of "Pulmonary" Pulmonary Hypertension

**Emmet F. Pearson, M.D.**  
**Springfield**

Treatment of "pulmonary" pulmonary hypertension with cor pulmonale should be directed primarily toward correction of the disorders of the respiratory system that cause increased resistance in the pulmonary capillary bed. Improvement in pulmonary physiology is reflected in improvement in the circulation. Gratifying improvement of subjective symptoms and objective signs may be obtained in most patients who suffer from right heart strain, secondary to chronic pulmonary disease, by combining several measures which partly correct lung derangements. These clinical observations are obtaining ample laboratory confirmation. Improved physiologic techniques, including direct study of pulmonary artery pressures by cardiac catheterization, have helped clarify some of the questions that formerly caused confusion and disagreements. We now have better insight into the types of lung disorders most likely to affect circulation, and the degree of lung change required to cause pulmonary hypertension. Physiologists do not agree on all points regarding the pulmonary circulation but clinicians do not wait until academic points have been settled to establish a working concept and a satisfactory treatment regimen.

Attempt has been made to correlate knowledge gleaned from studies made in cardiorespiratory research laboratories with personal clinical observations. The full force of physical, chemical, physiologic and psychologic procedures available has been used to treat patients who show evidence of pulmonary hypertension due to lung disease. (Other forms of pulmonary hypertension are not considered here.) The results obtained in this group of patients has been gratifying but are difficult to evaluate metrically or objectively. Most patients are greatly improved symptomatically, their work capacity is improved, and many have been able to resume some type of work after varied periods of complete disability. Our patients include many coal miners with pulmonary insufficiency whose welfare is of interest to the United Mine Workers Welfare and Retirement Fund. Some are patients in whom the Illinois Division of Rehabilitation is interested in getting back to remunerative occupations and others are private patients referred by general practitioners. This report is based on a two year study of 100 selected patients.

It has been shown that loss of one-half the pulmonary bed, as after pneumonectomy, adds no great strain to the right heart if the remaining lung is good. Extreme exertion may cause

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Read before section on Cardiovascular Diseases,  
Annual Meeting I.S.M.S., May 19, 1953.

temporary rise in pulmonary artery pressure after pneumonectomy but there usually is no impediment to the circulation. Simple attacks of bronchial asthma and most types of pulmonary infections, including pneumonia, cause little stress on the pulmonary circulation. Chronic pulmonary fibrosis, as in extensive pulmonary tuberculosis or moderate uncomplicated pneumoconiosis, rarely causes sufficient interference with pulmonary circulation to affect the heart. The pulmonary disorder that most consistently causes pulmonary hypertension is pulmonary emphysema; pulmonary hypertension often is in ratio to the severity and duration of emphysema.

Normally the right heart pumps blood at a pressure about one-fifth that generated by the left ventricle because there is low resistance in the pulmonary bed. Apparently the chief factor which controls pulmonary pressure is the intra-alveolar pressure. Intra-alveolar pressure becomes great in obstructive emphysema and impedes the blood flow through the easily compressed pulmonary capillaries. Resistance in the pulmonary bed, in addition to intra-alveolar pressure, is dependent upon the number and size of the capillaries, resilience of the tissues, total blood volume, rate of blood flow, and anoxia. In well advanced emphysema, stretching reduces the number and size of vessels. Increased pressure against the capillaries due to higher intra-alveolar pressure impedes blood flow and causes anoxia which, by a complicated chemoreceptor mechanism, leads to significant increase in pulmonary resistance thus establishing a vicious cycle of increasing anoxia and increasing pulmonary hypertension. This cycle may be interrupted partly by physiologically sound treatment.

When strain of the right heart becomes severe or is prolonged, the right ventricle responds by dilatation and hypertrophy. The usual objective evidence of right heart strain is obtained by x-ray of the organ which may reveal enlarged right ventricle or enlarged pulmonary conus and by the electrocardiogram which may show evidence of right heart hypertrophy. When these crude tests reveal abnormalities, the process is well advanced. Right heart strain may be estimated at an earlier stage by certain minor electrocardiographic patterns and possibly by changes induced by performance of the Valsalva strain while the ECG is being taken, which we

have done. Usually no change is detected on the ECG during the Valsalva experiment in normal subjects, but when pulmonary hypertension exists, increased strain thrown on the right heart may be indicated by change in the direction of right axis deviation. Distinctive changes are shown with the special vector cardiography, which may precede changes in the standard electrocardiography. The best method is by direct study of pulmonary arterial pressure by cardiac catheterization but this exact research evidence must find a substitute in the judgment of clinicians who utilize all available circumstantial evidence.

Objective findings in patients with pulmonary hypertension are not necessarily in direct ratio to the major subjective symptom which is marked dyspnea on slight exertion. These patients may be comfortable at rest but the slightest exertion loads the pulmonary bed, causing engorgement and extreme dyspnea. Other subjective features are general weakness, apprehension, productive cough, and sometimes chest pain. Some individuals, perhaps due to good psychosomatic control, appear to tolerate abnormal physiologic conditions better than others. The main objective findings of right heart incompetence in severe emphysema are persistent cyanosis, signs of chronic bronchitis, signs of bronchial narrowing, tense muscles and rigid chest wall, depressed and ineffective diaphragm, and decreased breathing capacity. All these disorders may be partly reversible. Treatment may influence directly pulmonary circulation by decreasing pulmonary resistance factors and indirectly by decreasing anoxia which is an important factor in increasing pulmonary hypertension.

Parts of the lung that have been destroyed or involved in severe fibrosis cannot be restored, but loss of lung tissue of pulmonary blood vessels is not the most important factor in causing pulmonary hypertension. The reversible disorders in the lungs which contribute to hypertension and which may be improved by treatments are:

- (a) Increased intra-alveolar pressure.
- (b) Bronchial infection with excess secretions and partly obstructed bronchi.
- (c) Edema of bronchial mucosa (allergic or irritative).
- (d) Constricted bronchioles.

- (e) Immobility of the diaphragm.
  - (f) Rigidity of muscles of the chest wall.
- Combined treatment consists of:

(1) Promoting bronchial dilatation by bronchial dilator drugs (aminophyllin), aerosol sympathomimetics (adrenalin).

(2) Clearing bronchial airway with old fashioned steaming, expectorants, or aerosol wetting agents (as alevaire), aerosol enzymatic digestants (tryptar), and sometimes bronchoscopic aspirations.

(3) Elimination of allergens and nonspecific irritants (cigarette smoke etc.) Occasionally, ACTH or cortisone in an effort to decrease eosinophilic infiltrations.

(4) Intermittent positive pressure breathing.

(5) Treatment of bronchial infection by antibiotics.

(6) Mobilization of diaphragm by pneumoperitoneum and emphysema belt.

(7) Psychosomatic therapy plus re-education in breathing habits.

(8) Phlebotomy, in far advanced cases of emphysema with polycythemia and hypervolemia.

(9) Cardiac supportive therapy, digitalization and salt restriction.

The particular bronchodilating drug most effective for each patient usually must be determined by trial. Unless other measures are used concurrently, the effects of any drug are short-lived. About one third of all emphysema and pulmonary hypertension cases were found to have an allergic factor not previously recognized. When there is an allergic component, and the allergen cannot be readily eliminated, ACTH or cortisone may induce resolution of the allergic (eosinophilic) infiltration of the bronchial wall. It is not justifiable to use these potent hormones without investigation of possible specific factors that may be eradicated. Elimination of non-specific irritants, smokes, and gases and avoiding rapid changes in weather may account for beneficial results experienced by some patients after change in residence or climate. Cigarette smoking is *harmful* to most patients and *should not be permitted*.

Expectoration of sputum and plugs is necessary for a good bronchial airway. When sputum is tenacious and the patient has ineffective cough, we have found alevaire (a detergent) inhalation by aerosol, to be better than steam inhalation.

Others have found the enzyme, Tryptar, effective in causing tough sputum to break up so that it can be cleared from the bronchial tree. Bronchoscopic aspirations serve a useful purpose in some obstinate cases, but a method for more continuous clearance is desired.

We use the intermittent positive pressure breathing treatment for 15 minutes two to three times daily on hospitalized patients (using the mine resuscitator or Bennet apparatus). Some workers have tended to discredit this procedure, but there is no question that the method has a permanent place in the treatment of most patients with bronchiolar obstruction and emphysema. This treatment helps mobilize stagnant sputum, forces air through partly obstructed bronchi, and tends to dilate small bronchioles forcing fresh air into alveoli and air sacs previously were stagnant.

When fluoroscopy reveals a low, fixed diaphragm with the breathing capacity greatly decreased and dyspnea marked, pneumoperitoneum will mobilize the diaphragm and improve breathing. Thereafter we usually provide the patient with a pneumatic emphysema belt to help keep the diaphragm in an advantageous position.

Many of these patients develop anxiety and tenseness which causes the extra muscles of respiration to become spastic and interfere further with normal reciprocal movements of respiration. Instruction in normal breathing and decrease of emotional tension is of immeasurable benefit. Moreover, when these patients realize that every effort is being made to help them after months or years of despair, their outlook and general psychosomatic machinery seem to work better.

In extreme and prolonged cases of pulmonary hypertension, polycythemia and hypervolemia may develop and add to engorgement in the pulmonary circuit. In these cases phlebotomy may be the most effective means of immediate symptomatic relief.

No one of these therapeutic procedures alone can be depended upon to bring about maximum symptomatic or objective improvement but utilization of all the methods at our command brings some degree of success in nearly all patients and great benefits are some. Many who have been totally disabled are able to return to work. A

few return to coal mining, but less arduous work is more suitable.

We assume that pulmonary hypertension is decreased by treatment. There is no good clinical method available to measure day to day pulmonary hypertension and right heart strain. We are unable to judge precisely, with ordinary laboratory and X-ray studies, what happens to the pulmonary artery pressure, and must depend upon circumstantial evidence. Since marked dyspnea on slight effort and cyanosis usually are strikingly improved, we assume that there is better pulmonary circulation and aeration. Edema of legs and liver may clear, indicating less backward pressure. One objective bit of evidence that could easily be obtained would be to determine intrapleural pressure before and after treatment, because this pressure in a rough way is in ratio to the intra-alveolar and pulmonary pressure. Occasionally electrocardiographic evidence of improvement in right heart strain occurs after relief by treatment of the pulmonary factors—e.g., more normal P waves and less tendency to right axis deviation. After relief from right heart dilatation, occasionally we see X-ray evidence of improvement by decrease in size. The pulmonary conus seldom decreases in size. There is less cyanosis, and a reduction in hypoxia may be shown by determination of arterial oxygen content, but this is not necessary for ordinary clinical work. The significant clinical feature is that these patients have much less dyspnea and chest discomfort, and a little improvement goes a long way when one is struggling for breath.

Of 100 selected cases treated as outlined, the rehabilitative feature has been most encouraging.

Precise figures are difficult to obtain regarding work because many were self-employed; in others there are many factors other than physical to be considered. Some have no will to work, others prefer a disability pension, and some work steadily who should be retired. I believe a fair estimate is as follows:

Return to full former employment — 20 per cent

Return to different employment — 30 per cent  
Symptomatically, greatly improved, but not working — 40 per cent

No improvement — 10 per cent.

#### SUMMARY

Many pulmonary disorders may influence the pulmonary circulation, but the disorder which most consistently has a detectable effect on the pulmonary circuit is pulmonary emphysema. Treatment for relief of pulmonary hypertension and right heart strain should be directed toward reversal of the factors that increase resistance in the pulmonary bed.

Combined treatment consists of measures to improve the airway through the bronchi, to improve aeration in the alveoli, to decrease the intra-alveolar pressure, and to mobilize the diaphragm.

Great improvement in subjective symptoms and some favorable changes in objective signs may be obtained in patients with varying degrees of pulmonary hypertension.

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# Leg Cramps in Pregnancy

## Prevention and Treatment

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Cramping pains in the legs are exceedingly common during pregnancy. Page and Page<sup>1</sup> found that while only fourteen per cent of indigent patients developed these symptoms, fifty-six per cent of private patients suffered from these cramps. They suggested that these painful contractions were due to an increased muscular irritability similar to a tetany, and caused by a decrease in the diffusible calcium and a corresponding rise in the inorganic phosphorus concentrations of the blood. They showed that this condition could be induced by either the use of large quantities of milk in the diet, or by supplementing their diet with dicalcium phosphate as a source of calcium. Page and Page also demonstrated that leg cramps could be prevented by reducing the intake of milk, the use of calcium salts free of phosphorus, and adding small amounts of aluminum hydroxide gel to the diet in order to remove some of the dietary phosphorus from the intestinal tract. They also showed that this symptom could be relieved by similar therapy.

*The purpose of this report* is to demonstrate the value of the administration of a dietary vitamin and mineral supplement containing a phosphorus free calcium salt and aluminum hydroxide gel (Calcisalin\*) in the prevention and treatment of leg cramps to a group of private pregnant patients.

### THE SYMPTOM

Leg cramps, as such, are commonly described as painful tetanic contractions of the gastrocnemius muscle. They usually occur in the morning upon arising and are brought on by stretching and a change in body position. These cramps often develop in the thighs and buttocks and are accompanied by a generalized muscular soreness and irritability.

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### RELATIONSHIP BETWEEN LEG CRAMPS AND CALCIUM

In 1930 Hartley<sup>2</sup> made the observation that a tetanoid state was common during the latter half of pregnancy. This syndrome consisted of symptoms of leg cramps, insomnia, irritable disposition, moderate edema, and paresthesias. He offered the possibility that this might be due to a disturbance of calcium metabolism. Mendenhall and Drake<sup>3</sup> (1934) reported the frequency of this tetanoid state. They found that relief was obtained when calcium, fortified with viosterol, was given in sufficient amounts. Early workers then were of the opinion that leg cramps were associated with an abnormal calcium metabolism during pregnancy.

### CALCIUM AND PHOSPHORUS METABOLISM IN PREGNANCY

The question of calcium metabolism in pregnancy as well as the clinical use of calcium compounds has been a much debated subject. Calcium is present in the blood serum in two forms: 1) a non-diffusible calcium which is bound to the serum proteins, and 2) the diffusible calcium which is ionized. Only the diffusible calcium is important in the etiology of leg cramps. The total blood calcium level declines during the latter half of pregnancy. There is a lowering of the diffusible calcium although the non-diffusible calcium is usually not altered or may be slightly increased. Phosphorus blood levels are unaltered.

### CLINICAL EXPERIMENTATION

Newman<sup>4</sup> studied the effects of therapy upon blood calcium levels. He found that various types and dosages of calcium phosphate and viosterol did not alter these levels. Gross, Wager and Loving<sup>5</sup> also found that the administration of calcium as dicalcium phosphate did not elevate the serum calcium or ionized calcium levels.

Page and Page<sup>1</sup> determined blood levels on ten pregnant women, nine complaining of leg cramps. The diffusible calcium in the blood

\*Calcisalin: (The Harrower Laboratory, Inc.)

was lowered and there was an increase in the inorganic phosphorus. Limiting the milk intake and increasing the elimination of phosphorus raised the blood level of diffusible calcium and lowered the blood level of inorganic phosphorus.

#### THE PREVENTION AND TREATMENT OF LEG CRAMPS

In our own investigations, the records of two hundred private patients were reviewed as controls. These patients were seen at regular intervals from the second month of pregnancy to delivery. All were of the middle economic class. Nutrition was not a problem, yet all were advised to eat two eggs daily; meat, fish or poultry daily on two occasions; and milk as tolerated. Dicalcium Phosphate with viosterol grains fifteen daily was started routinely at the fourth month. Leg cramps was a common symptom. One hundred and two patients (51%) complained of this at least once during the latter half of their pregnancy. Treatment was symptomatic — such as salicylates, rest and moderate exercise. Results were discouraging and this minor symptom was usually tolerated until it disappeared following delivery.

Calci-salin\* was given to a group of one hundred and twenty private patients. These patients were of the same economic group as the control cases. Again nutrition was not a factor and a similar diet was advised to this group. This supplement was started by the fourth month in all cases and in the third month in ninety-eight patients. Six tablets daily (two TID) were advised. Only fourteen patients complained of leg cramps during the latter half of their pregnancy. All fourteen admitted consuming three to five glass of milk daily, as well as large amounts of eggs, meats and ice cream. Nine of the fourteen did not take their tablets regularly as directed.

Of the fourteen having leg cramps, nine were relieved by eliminating milk and encouraging the use of the supplement as recommended.

#### DISCUSSION

The use of calcium as such has been advised to all pregnant women for years. It is recognized that the fetus obtains sufficient calcium from the mother regardless of her intake of this mineral. This is true even in locations where osteomalacia

is endemic. Fetal osteomalacia and fetal rickets are practically unknown. The relationship of maternal dental caries to calcium metabolism is a questionable one. Three glasses of milk daily plus liberal portions of meat and eggs has long been a dietary command to parturients. Dicalcium phosphate with Viosterol plus iron and vitamins have been prescribed as routine additions to the daily diet.

When Page and Page<sup>1</sup> demonstrated the large amounts of inorganic phosphorus in such a diet, and the effect of this diet (plus the phosphate salt of calcium) on the diffusible blood calcium and phosphorus levels, they opened the question of the efficiency of our present regime. Their demonstration of the relationships of this disturbed metabolism to the production of a tetanoid state as exemplified by the leg cramp syndrome has led to a revaluation of our clinical approach to this problem.

Reduction of phosphorus intake by eliminating milk, meat and eggs is not a feasible or practical measure. It is much simpler to prescribe calcium in a salt form that does not contain phosphorus. It is also simple to increase the elimination of dietary inorganic phosphorus by the addition of an aluminum hydroxide gel. The supplement used on this occasion embodies these principles.

Although leg cramps in themselves may be minor symptoms to the obstetrician, who is interested in the major clinical prenatal problems, they may be accepted as a possible diagnostic indicator of low calcium levels. There is also the matter of the patient's comfort to consider, for to the pregnant women leg cramps can be an extremely uncomfortable entity.

#### SUMMARY AND CONCLUSIONS

Leg cramps are common during pregnancy. They may be induced by a diet rich in phosphorus and made worse by the administration of the phosphate salt of calcium.

The cramps may be prevented by augmenting the diet with a vitamin, mineral supplement containing a calcium salt free from phosphorus plus an aluminum hydroxide gel which eliminates dietary phosphorus.

Only four per cent of the patients developed leg cramps while on such a regime as compared to fifty-one per cent of a group of control cases. Treatment of leg cramps was successful in

\*Supplied by the Harrower Laboratory, Inc.

sixty-four per cent of the group which developed symptoms.

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## Industrial Medicine and the Private Practitioner

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The private practitioner is the backbone of industrial medicine. This statement finds substantiation in the fact that 85% of all industrial medical work is carried out by physicians not serving on the premises of industry. Some 90% of all physicians engage in industrial medical work and this group of physicians serve on the average 50 patients yearly. On the other side of the situation, of those plants rated as being large establishments, that is having 2500 or more employees, only 46% employ full time physicians. In medium sized plants, that is those with a work force ranging from 500 to 1000 employees, 59% are served by physicians only on an "on-call" arrangement. In these medium sized plants, only one half of 1% employ a full time physician. Further down the scale as to size of work establishment, that is up to 500 employees, 41% are served by physicians on a "on-call" basis while the majority have no arrangement whatever with any physician.

As a result of this simple recital, it must become apparent that the private practitioner outstandingly is the source of medical services to industry. In a measure, the statement is justified that with few exceptions every physician is an industrial physician, a fact little recognized by these physicians themselves and in truth there is obvious reluctance on the part of many to accept any identification with industrial medicine.

Industrial medicine as practiced through in-plant services and on a full time basis leads to the setting apart of some 2500 physicians as specialists in industrial medicine. The quality that distinguishes these industrial medical specialists from that much larger group that includes some industrial medical work within its activities is that the former is well familiar with the technology of his particular industry and perhaps may be conversant with the technology of many industries. If petroleum products manufacture may be accepted as a suitable example, it may be pointed out that that type of manufacture starts with a single raw material — crude petroleum oil, but through suitable manipulations and refinements that crude oil ends up in some 700 different products with everyone requiring its own peculiar technological steps. This large number manifestly will embrace various grades and modifications of gasoline, several types of naphtha, a variety of oils, and extensive number of waxes, an array of tarry chemicals. Toward the end of these examples there might be mentioned some forms of synthetic rubber that are well dependent upon petroleum derivatives as one essential constituent. The physician in industry who moves with facility within all of this sort of technical requirement becomes the true industrial physician assuming always that in addition he is suitably qualified in the requirements of good medicine.

As a corollary to the foregoing it becomes apparent that the industrial medical specialist

need not know the technical requirements of all industries but perforce must be familiar with the industrial activities of his own particular industry. With such knowledge he is placed in position to shape his program to the needs of his particular work force. Medical activities in a large department store in the majority of its requirements will not differ from those suitable for the work group in a steel mill. However, over and above those shared requirements a good industrial medical program will be conditioned and modified to the precise demands imposed by trade processes. Clearly the nature and extent of preplacement physical examinations will incorporate distinct differences as to a department store and a steel mill.

Recently a large corporation seeking the full time services of a skilled medical director, listed the duties entailed in terms of functions. Omitting some items as irrelevant or too revealing, the list is here introduced:

*Medical Functions:—*

1. Develop, administer and coordinate medical programs, services and facilities.
2. Supervise all medical personnel.
3. Responsible for all medical equipment and supplies.
4. Advise, with essential supporting data, as to the development and administration of medical policies and standards, modification of existing policies, standards or procedures.
5. Contribute to high level personnel efficiency in the plant through planning medical programs calculated to encourage such efficiency.
6. Make periodic audit of compliance with established medical policy.
7. Develop appropriate, desirable and required programs such as preemployment medical examinations, periodic health examinations, minor medical and surgical treatments, post-absence examinations, health education and counselling, employment placement plans and retirement counselling.
8. Participate, as desirable, in public health programs.
9. Develop health education programs designed to instill health consciousness in employees and supervisors.
10. Promote and coordinate executive health examination programs.
11. Collaborate in the establishment of physical

and mental requirements of jobs, in the investigation and determination of health hazards which may be involved and in the speeds of production and physical standards generally.

12. Develop and administer appraisal of medical and health research programs designed to advance industrial medicine and surgery.
13. Collaborate and cooperate with other responsibilities in effort to eliminate unhealthful working conditions and practices.
14. Plan, administer and coordinate industrial hygiene research programs.
15. Develop standards of selection, training and promotion of nurses and non-professional hospital employees.
16. Designate professional personnel for special consultation as required.
17. Recommend professional medical personnel as required as arbitrators or participants in arbitration proceedings relating to employee health, physical qualifications, or health hazards.
18. Develop and maintain training or informational program for Medical Department personnel as required.
19. Cooperate, as desirable, with medical schools in education and training of industrial doctors.
20. Cooperate with Director of Safety in the development of safety programs, safe working conditions, and protection against fatigue, exhaustion and health hazards.
21. Cooperate with Directors of Employment and Training in the development of placement and transfer policies applicable where employment changes may be desirable because of physical or health conditions.
22. Establish and administer rules and procedures controlling the conduct of emergency hospital, clinics, dispensaries, facilities for diagnosis, treatment, investigation, transportation, records — consistent with adequate medical standards and appropriate economy.
23. Periodically inspect hospital and dispensary facilities to assure proper medical, surgical, hygiene and ethical services.
24. Provide review and advise concerning appropriation requests for hospital, dispensary, medical equipment, sanitary facilities, from the viewpoint of proper attention to health standards.

25. Advise management associates concerning public relations or political aspects of medical or health programs.
26. Maintain continuing familiarity with medical developments generally as they may relate to employees' health.
27. Participate, as desirable, in national or regional medical associations meetings.
28. Maintain interest in and appropriate relations with recognized, established agencies such as American Red Cross and American Industrial Nurses Association.

This long recital need not grievously concern the private practitioner. This is presented for two objectives. First, here are displayed all those qualifications apart from usual medical attainments, the possession of which mark the industrial physician as a medical specialist serving in a distinctive field. Secondly, it will become evident that the more the private practitioner may make contributions to industry along any of these mentioned functions, the more valuable his services become. Fully it will be apparent that small industry which is the stronghold for the industrial medical activities of the private physician, never or rarely, include such elaborateness in the medical programs.

If it be agreed that tremendous significance is to be attached to the techniques of industry as an essence in good industrial medical work, any number of difficult situations as to the private practitioner becomes clear. A part of the reluctance of the private practitioner to regard himself as part of the total industrial medical force is because of his recognized lack of acquaintance with industrial pursuits. The acquisition of such kinship with industry becomes enormously difficult. If perchance the private practitioner serves patients deriving from twenty or more different industries, everyone with different technological activities, as all too often happens, the private practitioner may make disturbing diagnoses and with particular reference to occupational diseases. More often than not all such spring from insufficient understanding of industry's machines, materials, chemicals, intermediate processes and their like. On rare occasion the private physician becomes an instrument in the iatrogenic diseases. Unfortunately in these rare instances, he may make diagnoses of occupational disease that not conceivably could

have arisen because in the plant involved there was utterly no opportunity for exposure to the causative factor for the occupational disease in question. By way of example, from a lamp black factory, and truly a dusty one, a patient appeared in the office of a private practitioner and in due course a diagnosis of "silicosis" was attached to a well established lung affection. As to exposures in that lamp black factory, starkly there was no opportunity for exposure to silica, the single causative agent leading to silicosis. In truth, silicosis may have existed and the diagnosis may have been precisely correct, but any such condition unfailingly would have been caused by exposure in some earlier employment. In reality as to this instance, the damaging exposure was connected with previous coal mining in another state. Yet in such matters, the skilled and well meaning private practitioner inaugurates through his lack of full exploration of the work situation a series of disturbing and expensive circumstances conducive to disaffection on the part of the worker himself and his family and the employer, all of which ultimately involve the private practitioner.

If any portion of these contentions be true, a measure of remedy quickly is in sight. Show to the private practitioner the industrial pursuits of his community. Permit him better to qualify as the able industrial physician by demonstrating to him the processes of industry that surround him.

At this time as an educational procedure in university areas, a fair number of symposia yearly are provided related to industrial medical topics and designed for the private practitioner. All this is fine and there should be more of such discussionals and there should be larger attendance on the part of the private practitioners. One of the outstanding opportunities in these symposia is for the period to forget about learned didactic presentations and instead to conduct the entire group of private practitioners through a whole series of manufacturing establishments, perhaps one every half day and for a period of 4 to 5 days. This one step, at least for the small group of participants concerned would do more toward eliminating the aversion, the repugnance and the uncertainty of the private practitioner toward industrial medicine than any dozen informative lectures or any dozen textbooks.

A fine opportunity for bettered intraprofessional relations beckons to the full time industrial physician and particularly in the smaller industrial communities. Once yearly arrange for the county medical society to meet on the plant's premises. Provide a dinner and a good one. Forget the scientific papers; forget the plant medical appurtenances however admirable. Instead, take the private practitioners into the factory. Show them such things as a monitor lathe, a drill press, a vapor degreaser, a paint spray booth, a heat treat department and a welding operation. Permit these physicians to get just a few metal shavings or a little plastic dust into their own pants' cuffs. That is the badge of the qualified industrial physician!

The desirable partnership between the private physician and the industrial medical specialist is a natural one. Of any 100 serious complaints reaching the plant dispensary, some 90 have nothing to do with plant operations as to causation. Yet, the workman so afflicted is just as much a detriment to the plant's activities and to himself as though he had incurred in the factory a broken finger or a severed ligament. Wholly is it impossible for the plant physician to be concerned only with that portion of a workman who works 8 hours daily. Equally is it impossible for the private practitioner to segregate and minister to the workman's 16 hour affections when he is away from his employment. Physical or mental disturbances are 24 hour affairs and the

workman is a whole human being throughout the 24 hour day. The plant physician has no purpose or willingness to provide medical services for non-occupational affairs beyond emergency care or beyond trivial conditions. That becomes the function of the private physician. Still what that private physician does or does not do is just as important to the workman and to the employer, as any ministrations on the plant premises.

Inescapably it comes about that the private practitioner, whether he recognizes it, whether he be willing, whether he plans it, perforce becomes the major medical factor in keeping the workman at work and earning his wage.

Presently, in terms of need but not necessarily in terms of demand, there is a shortage of some 4000 full time industrial physicians. To offset this shortage, universities yearly are turning out only about 30 to 50 skilled trainees. Even though that deficiency fully were met the situation would remain the same. The backbone of industrial medicine is the private practitioner. Industry knows this; the industrial medical specialist knows this; but the practitioner does not. For all foreseeable time, industry expects to rely upon the private physician to serve industry's work force. Industry invites the good private practitioner to become even more proficient through familiarity with the very essence of occupational health — industrial technology — the mechanics of industry.

# Burns — A Plea for Early Definitive Care

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The nightmare complications of severe burns can frequently be avoided by proper early care and attention. The immediate life saving measures are usually well handled. When the acute crisis has passed, attention must be directed towards healing of open lesions. Many methods of treatment have been advocated and undoubtedly they have all given excellent results. But each burn patient not only merits but *must have individual attention*.

The unfortunate feature of most of the contractures in burns is the delay that is permitted in definitive treatment. All burns involving the face, neck, hands and joints must be handled with dispatch as soon as the systemic condition permits in order to avoid the horrible results that almost inevitably follow delay in definitive care. Amyloid infiltration of the viscera and nephritis are not uncommon systemic complications when coverage of the open wounds of extensive burns has been unduly prolonged. It is the duty of every physician who is called upon to treat and care for burned patients, to relieve pain and shock, to maintain the general well being of the patient, to promote healing of open wounds, and to return the patient to normal function and appearance as early as possible.

The local pathology is so well known that no further discussion should be required. The first dressing usually requires a general anesthetic if the burn is of the deep 2nd° or 3rd° nature. It is at this time that a definite plan of local treatment should be outlined. Variations may, of course, become necessary, but the basic principles of the treatment must be maintained once they have been established. The sad and unfortunate picture in many instances is that once the nutrition has been elevated and the wounds cared for by dressings, relaxation on the part of the attendants sets in and the excellent vigorous early care begins to lag instead of being carried on to completion.

All burns require *a great deal of individual attention*. *There are no short cuts*. Proper records must be kept to note the progress of the patients — the urine must be examined regularly — blood counts must be done at frequent inter-

vals — the hematocrit determination must be frequently performed until a normal level has reached a plateau. The blood chemistry must be well within normal limits. All these factors must be watched and watched carefully. When they have all reached a satisfactory level, and if there is no evidence of local infection, then attention should be directed towards covering the open wounds with split thickness skin grafts. Contractures are prevented only by early skin grafting. Splinting will not prevent contractures nor will the application of plaster casts alter this pathologic result of burns. Such procedures only mask the true situation and all treatment should be directed at preparing the areas for grafting at the earliest possible moment, to prevent these unfortunate complications — contractures and deformities. Procrastination of this vitally important step is the cause so often of the crippling effects of contractures. Pinch grafts are mentioned at this time only for condemnation. They destroy donor sites for future grafts and produce hideous scarring in both the donor and recipient sites.

If the attending physician has brought the patient past the crisis where life and death are no longer in a nip and tuck balance, he should not be guilty of commission in the proper definitive care of the open wounds. There is no need for patients to emerge with ectropion of the lower or upper eye lids or with such scars on the face that the eyes are forcibly opened when the mouth is opened. There is no longer any need for severe burns of the neck to result in a chin-chest contracture with its attendant sialorrhea and intraoral complications, and the numerous operations and long period of time necessary for reconstruction and rehabilitation. There is no longer any need for patients to be limited in extension of their forearms or abduction of their upper extremities (and/or wrists), and legs (and/or ankles) by inelastic fibrous tissues. There is certainly less need for crippling of hands due to scar contractures.

To allow a large superficial wound to heal by granulation should be considered a surgical failure. The production of rigid scar tissue

in burn wounds involving joints is a most serious complication from a functional and rehabilitation standpoint. Excision of this inelastic tissue may be a very tedious and exacting procedure and it may not be possible to remove at all. Better results are obtained if the open

wounds are covered before scar tissue has formed.

This plea is made for adequate definitive care of these unfortunate people so that they may be able to return to normal function as early as possible.  
25 E. Washington St.

# Cancer of the Lung

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Deaths from cancer of the lung in Illinois continue to increase steadily as shown by the following table:

TABLE 1  
DEATHS FROM CANCER OF BRONCHUS,  
LUNG AND PLEURA AS COMPARED TO  
TOTAL CANCER DEATHS, ILLINOIS 1940-1952.

Year	Total Cancer Deaths	Deaths from cancer of Bronchus, Lung & Pleura	Per cent of total
1940	11,147	551	4.9
1941	11,396	637	5.6
1942	11,650	700	6.0
1943	11,959	757	6.3
1944	12,328	797	6.5
1945	12,652	859	6.8
1946	12,820	952	7.4
1947	13,500	1077	8.0
1948	13,863	1123	8.1
1949	14,141	1226	8.7
1950	14,430	1381	9.6
1951	14,785	1503	10.16
1952	14,988	1560	10.41

Although a satisfactory surgical technique has been developed and operative mortality from lung cancer is low, not more than five per cent of the cases are cured. Potentially, with earlier diagnosis, cures could reach fifty per cent. The problem, therefore, is how to increase the number of early lung cancer diagnoses.

Today, the only means available with which to cope with this situation is the chest roentgenogram. Accumulated evidence has shown that early bronchogenic carcinoma can be discovered

in this fashion whether the roentgenogram be taken as part of a regular physical examination, a hospital admission or a community chest survey. For such a program to reach its maximum effectiveness, more people must submit to chest roentgenograms, particularly men over forty. At the present time radiologic facilities of this nature are far from being taxed to the limit of capacity. Therefore, promotional effort in this direction will not place an impossible burden on radiologic personnel and equipment.

Action has already been taken to get more people to have roentgenograms of the chest at regular intervals. The groups actively participating in this project are the Illinois Division of the American Cancer Society, the Illinois Tuberculosis Association, the Illinois Heart Association, and the Illinois Department of Public Health. With regard to lung cancer, there will be added emphasis on men over forty. As an adjunct to this effort will be a wide showing of the American Cancer Society's new film *The Warning Shadow*, which deals with lung cancer in a popular fashion.

While the work of these organizations will produce results, there is an untapped potent force that could add greatly to the accomplishment, namely, the family physician. It is his duty to urge and arrange for the roentgenographic screening of his patient population. His immediate and continuous active participation is a required step in such a program.

# Diagnosis and Treatment of Secretory Otitis Media

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The otologic problem of secretory otitis media is not a new one. It was described by Politzer<sup>1</sup> as early as 1869, and has appeared in the literature at infrequent intervals since that time. For want of a better term, it has been variously called serous otitis media, otitis media with effusion, and catarrh of the middle ear, as well as secretory otitis media and other lesser used terms.

Evidently there is an apparent increase in the incidence of the disease due to a greater awareness of the possibility of its presence and greater vigilance of otologists in diagnosing it. Hoople<sup>2</sup> is in no small measure responsible for the increase in the number of cases being diagnosed, for it was he who emphasized the lack of teaching concerning this entity in our medical schools, in our text books and post-graduate courses. However, it would seem that there is a very definite real increase, as well as an apparent one, in the incidence of this malady, and it would seem that the real increase is largely due to the increased and often indiscriminate use of antibiotics for the treatment of upper respiratory infections, particularly in children. All too often antibiotics mask the findings of acute otitis media, an indicated myringotomy is not performed, and secretory otitis media results, with consequent hearing loss. Again, all too often, the hearing loss is blamed on the subsiding acute otitis media, and the diagnosis of secretory otitis is delayed, or in some cases, possibly never made. Partial blame for the increased incidence must also be laid to the increase in commercial flying.

The incidence and importance of this disease can be readily grasped from a very few simple figures. A spot check revealed that roughly thirty four per cent of patients seen in the author's practice, a general otolaryngologic type

practice, are cases of hearing loss from all causes, simple or complex, remedial or non-remedial. Between three and four per cent of these patients with hearing loss have secretory otitis media.

While some cases of the disease, particularly in children, will clear up with local therapy of the nasopharynx and Eustachian tubes orifices, it has been my experience that the vast majority require myringotomy. The purpose of this paper is to review the findings and results in one hundred forty-four unselected patients with secretory otitis media that necessitated myringotomy. The small percentage of cases responding to more conservative measures will not be included in this discussion. These patients were all seen in private practice from July, 1946, to December, 1952. It is hoped that more light can be shed on some of the mysteries of this perplexing problem by such a review.

One hundred six of these patients, or seventy three per cent, had unilateral secretory otitis media, while the remaining twenty seven per cent had bilateral involvement. The figures therefore represent a total of one hundred eighty two ears in which the condition was encountered. Seventy seven were males and sixty seven females. Twelve were children under ten years

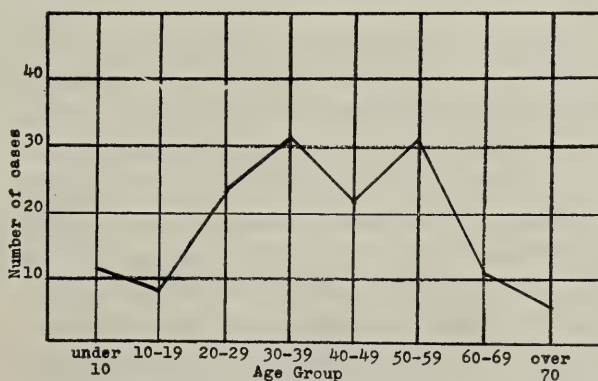


Fig. 1. Incidence of secretory otitis media by age groups

of age. As shown in Figure 1, the largest number of patients was encountered in the thirty to thirty nine and fifty to fifty nine age groups. Whether there is a greater incidence in those groups or they are more concerned with their hearing at those ages I do not know.

Presented before the Section on Eye, Ear, Nose and Throat, 113th Annual Meeting, Illinois State Medical Society, Chicago, May 19, 1953.

From the Department of Otolaryngology of Northwestern University Medical School and St. Luke's Hospital, Chicago.

The primary complaint was loss of hearing acuity in one or both ears, although many patients complained only of a 'blocked' or 'stopped-up' feeling in the involved ear. Tinnitus, although often considered important, was a complaint in exactly one half of the one hundred forty four cases, and therefore can only be considered of secondary importance as a help in diagnosis. Nor was there any definite type of tinnitus noticed, it being variously described as a ring, buzz, crackle, hum, popping, whistle, click, steam or throb. Certainly it is of diagnostic value when described as a splashing or gurgling sound on movement of the head. However, this type of tinnitus is noted only in the tympanum which is partially filled with fluid, a relatively rare finding.

Figure 2 shows that duration of symptoms prior to examination varied widely, from eight hours in one case to ten years in another. Eighty four patients had symptoms from one to four weeks, while thirty seven had complaints present for less than one week. The condition had been present from two to eleven months in thirteen patients, and for a period of one or more years in ten patients.

	Number of Cases
Less than one week	37
One to four weeks	84
Two to eleven months	13
One year or more	10

Fig. 2. Duration of symptoms in 144 patients

Hearing loss determined audiometrically was as low as forty six decibels in one patient, while in others hearing was found to be normal. The average patient with secretory otitis however, showed a loss of from ten to twenty-five decibels, with a slightly greater loss for high tones than for low tones in most cases. Decibel loss from secretory otitis was measured from what the patient described as his normal hearing after he had recovered from the disease, not from the base line of the audiogram, for a considerable number of patients, particularly the older ones, also had perception deafness of varying degree. The degree of hearing loss did not appear to be related to the duration of symptoms.

As to etiology, the most common predisposing ailment was an acute upper respiratory in-

fection. Ninety-two patients, or sixty-four per cent, had such a preceding infection. In ten patients the difficulty was traced to an airplane flight, while eleven had been tying with an acute cold. About ten per cent of these patients with upper respiratory infections had been treated with antibiotics, either prescribed by a doctor, or taken without medical advice. Seven cases began with acute otitis media. All of these had been treated with antibiotics. Three cases were preceded by myringitis bullosa, which has also been noted by Senturia<sup>3</sup>. Nasal polyps accounted for three cases and definite allergy to cosmetics for one. The only cause in one patient appeared to be accumulation of secretions in the nasopharynx in an older person who was at complete bed rest because of lymphangitis. In thirteen patients no etiologic factor could be determined.

In the group of adults, tonsils or tonsils and adenoids had been removed in one hundred two patients. The remaining thirty still had their tonsils, but they did not appear to be a factor. However, in the group of twelve children under age ten, nine had very hypertrophic adenoids, or both adenoids and tonsils. Three children had had their tonsils and adenoids removed previously because of their hearing loss, but the diagnosis of secretory otitis had been overlooked. In fact, in one case, a child, the otolaryngologist had not even examined the ears.

Regarding diagnosis, a history of rapid onset of unilateral or bilateral hearing loss, with or without tinnitus, should lead one to suspect the disease. If the physician is fortunate enough to have a patient describe a splashing or gurgling sound in the ear, or a feeling of something moving in the ear when the head is tilted from side to side, the diagnosis can almost be made without examining the ear. Many complain of a 'blocked' or 'plugged' feeling in the ear or in the head.

The typical appearance of the tympanic membrane in cases of secretory otitis has been described by Hoople<sup>2</sup>, Jordan<sup>4</sup>, Suehs<sup>5</sup>, and others. The presence of a fluid level, or meniscus, on examination of the tympanic membrane is rare, having been seen in only seventeen, or nine per cent of the total of one hundred eighty two ears under discussion. The typical drum finding in the patient with a translucent drum

membrane is an amber color or cast. It may vary from red amber to bluish amber, but it is unmistakably present and not difficult to differentiate from the normal drum. In cases where the drum is opaque or thickened, the diagnosis can be made by auscultation with gentle catheter inflation of the Eustachian tube. The safest way to describe the sound heard by auscultation is to say that it is not normal. If the tympanum is not entirely filled with fluid there may be a bubbling sound. In a full tympanum there may be a chugging, grating, or crackling sound. With a little experience one soon learns the sounds associated with fluid in the middle ear. If the diagnosis is still in doubt after auscultation, a diagnostic myringotomy should be performed, for it is less detrimental to the patient and less embarrassing to the physician to open a dry ear than it is to miss a diagnosis of secretory otitis media by being timid about using a paracentesis knife. If fluid is found by diagnostic myringotomy, treatment has already begun.

Treatment in these cases consists in ridding the ear of fluid by myringotomy and catheter inflation or spot suction, and treating the factors, if present, which tend to cause blockage of the Eustachian tube. In the majority adults the blocked Eustachian tube is due to edema from upper respiratory infection. Fluid remains in the ear however, after the infection has subsided, and rarely will these cases be cured by mere catheterization and inflation. I have theorized that the blocked tube causes secretory otitis, and the presence of fluid in the middle ear causes further edema of the tube, so that a vicious cycle develops. This cycle can only be broken by myringotomy, thereby removing fluid from the ear and allowing it to become ventilated from the outside. Pressure is then equalized on both sides of the tympanic membrane and the tube then returns to normal. I have not found that catheterization is harmful to the Eustachian tube nor does it cause persistence of edema.

In this series of one hundred forty four patients, five hundred sixty two myringotomies were performed, an average of three and nine tenths per patient. In nearly half, one myringotomy was sufficient. A little over twenty five per cent required two or three incisions, and the remainder required four or more. Nine

patients of the group required more than ten incisions, one case required fifty one.

Contrary to some opinions I have not found that repeated myringotomy has been harmful to the drum or middle ear, for once the ear has become dry the hearing returns to normal, and one is hard-put to differentiate a normal drum from one that has been opened twenty or thirty times.

The fluid obtained at myringotomy has been examined and cultured in a number of cases. As has been demonstrated by Suehs<sup>5</sup> and others, no bacteria were ever found, nor any cells that would aid one in determining etiology or therapy.

The fluid is most often serous, but may be mucus. Removal of thick tenacious mucus from the middle ear by inflation is difficult or impossible, therefore suction must be used. Although serous and mucus ears tend to remain that way, I have seen serous ears become mucus, and vice versa. The change from serous to mucus is more frequent than from mucus to serous. I have not found that change in character of fluid is a prognostic sign.

One must be guarded in his prognosis of these cases, for although it may be stated in general that the shorter the duration of symptoms, the more quickly a cure can be effected, this does not always hold true. One patient, a fourteen year old boy, had been hard of hearing for three years. He had been seen by no less than five otologists who had told his mother that he had nerve deafness, that he would soon be totally deaf, and that he had best study lip-reading. Examination revealed both drums to have a dark blue color to them, almost as if the jugular bulb were projecting into the middle ear cavity. After myringotomy a thick, almost solid clump of mucus was removed from each middle ear. Within a week hearing returned to normal and the ears remained dry. On the other hand, patients who have had symptoms for only a few days or weeks may require months of treatment before the ears become dry.

The persistent cases are the most trying to doctor and patient alike. The ear continues to refill after repeated myringotomies. In spite of Jordan's<sup>4</sup> figure that about seventy per cent of these cases are allergic I have found only a few where allergy could be blamed. All per-

sistent cases are given antihistamines as a therapeutic test, but less than five per cent have shown favorable results with this treatment. The majority of chronic cases have benefited by creating what I have termed a semi-permanent perforation in the drum. Such a perforation can be made by making a C-shaped or an I-shaped incision in the drum. Many of these will remain open for as long as three to four weeks, usually sufficient time for the tube to return to normal, and in sharp contrast to the linear incision which usually is closed within forty-eight hours. The few perforations that do not close spontaneously can be caused to heal at will by the usual methods of closing chronic perforations.

The children in this series require special mention, for without exception their ear disease was the result of hypertrophic adenoids. As mentioned earlier, the only children included in this discussion are those whose ears did not clear up under conservative therapy such as shrinkage and nasal hygiene. All were treated by tonsillectomy and adenoidectomy, with myringotomy and catheter inflation being done at the same time. All were cured save one, who eventually required bilateral simple mastoidectomy with external drainage until serous discharge ceased. At operation all the mastoid cells contained serous fluid. Another child had a recurrence about six months later. There had been tremendous adenoid regeneration. Adenoidectomy was repeated and followed by irradiation of the nasopharynx. She has been free of recurrence for one year.

Speaking of nasopharyngeal irradiation, I have used it in these cases in two adults who had recurrent attacks of secretory otitis due to flying. Since their business demanded frequent air trips irradiation was decided upon. Neither case has had a recurrence for over two years. However, I want to go on record as being against irradiation of all cases of secretory otitis as a routine procedure, even in chronic cases.

Of the one hundred forty-four patients under discussion, four discontinued treatment before they were discharged as cured. One patient is still undergoing treatment after two years, and I am afraid he must be classed as a case that may never be cured. The remainder have

been classified as cured, with hearing returned to normal.

Two patients later developed cholesteatoma in the involved ear, although there were no symptoms or findings of cholesteatoma at the time they were seen with secretory otitis media. One, a girl aged twelve at the time she was first seen with bilateral secretory otitis that had been present for two years, was seen one year after being discharged as cured. She had left sided attic cholesteatoma which necessitated modified radical mastoidectomy. The second, a fifty-five year old male, was seen six years after having left secretory otitis. He had left attic cholesteatoma which to this date has not necessitated surgery. These two cases lead one to speculate as to whether or not secretory otitis media may be the cause of many cases of so-called primary attic cholesteatoma.

I believe the following conclusions may be drawn from this review:

Secretory otitis media is being encountered more frequently and being diagnosed more frequently than previously, but many cases are still being overlooked.

Etiology of the disease is blockage of the Eustachian factors. Once fluid has formed in the middle ear, it too becomes a factor causing stachian tube, due to infection, allergy, or mechanical blockage of the tube by causing persistent edema of the mucosa. Allergy was rarely found to be a predisposing factor in this series.

Secretory otitis media may cause a considerable hearing loss, but if proper treatment is instituted the loss is a reversible one.

The diagnosis is made from the history, appearance of the tympanic membrane, inflation and auscultation of the middle ear, and diagnostic myringotomy if necessary. The diagnosis is rarely made if one does not suspect the possibility of fluid in the middle ear.

Although conservative therapy may often be of value in children, it rarely is so in adults. Myringotomy is almost invariably required, and must be repeated as often as necessary. Repeated myringotomies do not appear to be harmful to the tympanic membrane.

Secretory otitis media in children is usually an indication for tonsillectomy and adenoidectomy, particularly the latter.

Prognostication is difficult for often there is

no relationship between duration of symptoms and time required to effect a cure.

Mastoidectomy may be necessary in some cases, but only rarely.

Secretory otitis media may be a predisposing factor in some cases of primary attic cholesteatoma. Only time and experience will prove or disprove this point.

Although much is known of this disease, there is still much to be learned about it. The most important step in this learning process is that

the diagnosis can be made promptly in all cases.  
307 No. Michigan Avenue

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## Surgery of the Aged

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Our aging population is rapidly becoming a subject of increasing interest, and a vast potentiality for retained capabilities of effort. According to Dublin about 2.5% only, of our population in 1850 was over 65. During one century this percentage trebled and is still continuing to rise. We see an even greater rise in that percentage of our population over 45 during this same century of progress i.e. 10% to 30%.

If for no other reason than actual numerical increase, the surgeon, as well as all other practitioners, will encounter a larger group of patients in the older age brackets. Many of us have a personal, as well as professional interest in this ever-increasing group. We can aid these people in their ability to maintain their physical integrity, thereby, reducing dependency for invalid care. The intermittently or chronically ill person is a menace to himself and a millstone on the neck of his family. At the same time this group is becoming much better educated as regards their anatomy and physiology, and are much less willing to abide the correctible abnormalities with which some of our ancestors lived and died.

Geriatrics has become a well recognized word

to the laity as well as the medical profession. Oberhelman has pointed out the difficulty of establishing an age line of demarcation and arbitrarily sets definition at 70 years. This is a chronological age line; biological age considerations will give us a much better evaluation and control of the individual patient. A patient who is 40 years of age and manifesting hypertensive cardio-vascular-renal disease is little better candidate for emergency or elective surgical procedures than a 75 year old with the same deficiencies.

We are agreed upon the fact that avoidance of emergency surgery, particularly in the aged, but wherever possible, is an important prophylaxis of catastrophe. Cole estimates an over-all mortality rate in cholecystectomy of 2-3%<sup>3</sup> as compared to Behrends report of mortalities of 11.7-16.6% for biliary tract surgery in elderly people. Fisher and White<sup>5</sup> report an operative mortality rate of 21.6% in a series of 80 operative cases. Haug and Dale<sup>6</sup> report 33 major operations of all types in patients over 60 years of age. Their over all mortality rate for the entire group was 9%. The rate for emergency procedures was 21.9% as compared 5.7% for elective operations.

From these figures we may draw two conclusions; that it may be wise judgment to subject our patients to elective surgical procedures at

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an earlier age in order to avoid the slightly increased mortality rate of elective surgery in the aged patient; and that the reduction of as many emergency conditions to elective procedures is necessary.

It is essential in the evaluation of the elderly surgical patient to assay his condition both from a clinical as well as a laboratory standpoint. The fact that he was able to tolerate a moderate amount of exertion without evidence of myocardial insufficiency may be much more useful than electrocardiographic evidence of coronary artery disease. A history of long-standing dietary inadequacies may be given a much greater consideration than a battery of laboratory information demonstrating a mild anemia, normal protein levels, and normal electrolyte balances. The presence of varicosities and a history of phlebitis and claudication may be of much greater significance than a normal oscillometry of the lower extremities. In other words an adequate history plus the application of the principles of physical diagnosis will give us a fair summary of the patient's ability to withstand the rigors of an anesthetic plus surgical trauma.

As stated by others:<sup>6</sup>

"With proper preoperative preparation and postoperative care, the risks of surgery can be greatly reduced. This is extremely important in old persons who lack the reserves of youth. Prevention of complications must be strongly emphasized. Early active treatment of complications that do occur is necessary to prevent a vicious cycle of events, each further reducing function in vital systems. Old persons cannot be operated upon without prior preparation or be allowed to convalesce undisturbed if prohibitive mortality is to be avoided. Continual care and alertness to their needs are necessary."

It is reported that the most frequent geriatric surgical procedures are done for hernia, biliary tract disease, rectal lesions, peptic ulcer, carcinoma of the stomach, carcinoma of the colon and carcinoma of the breast in about that sequence<sup>5</sup>. These are debilitating conditions with the exception of hernias. Nutrition in all usually has been disturbed for some period of time. Preoperative restoration of water, plasma, blood, protein, electrolyte and vitamin deficiencies must be accomplished preoperatively in order

that complications be avoided. Intravenous alimentation is not as satisfactory as the oral route for this accomplishment but must be resorted to in emergency circumstances. Antibiotic control of co-existing infectious processes must be established.

The use of digitalis<sup>7</sup> is well appreciated where there is a disturbance of rhythm and resultant circulatory insufficiency. More important however is the use of digitalis preparations in elderly patients without evidence of severe decompensation, where surgical conditions exist. Many of these people are able to tolerate their normal daily routines; however, when additional stress is applied, function is inadequate. Digitalization, partial or complete, preoperatively or immediately postoperatively, particularly in the presence of fever or infection, is to be strongly emphasized. Its action may be summarized in these cases as one of increased myocardial tone. Prolonged therapy may not be necessary but 71 digitalis may be one of the most useful supportive measures available in transporting a surgical patient through a period of crisis.

One of the most distressing post-operative complications seen in any group of surgical patients, and only indirectly related to the surgical procedure, is phlebothrombosis and pulmonary embolism. Especially in the geriatric patient, the tissue turgor generally is reduced. This coupled with disturbances in cardiac rhythm, variations in clotting mechanisms from any cause, reduced blood pressures during anesthesia, venous stasis due to compression of vessels of the extremities while patients are on the operating table, and the post anesthetic lassitude of the elderly patient make for a higher rate of this complication in this group of patients. Elastic support of the legs has been recommended postoperatively. It might be well to utilize this prophylactic measure preoperatively and continue it through the early postoperative phase of convalescence.

By way of clinical material, I would like to add a small, unselected, group of 33 patients in whom 36 operations were performed. The average age of these patients was 68.5 years, the oldest being 87 and the youngest 52. There were only three emergency surgeries in this group, two for appendicitis and one because of

Figure 1

Pt.	Age	Operation	Diagnosis	Result	Complications
JM	77	Appendectomy	Appendicitis	Good	.....
BG	66	Transversostomy	Carcinomatosis	Satis.	.....
BF	64	Proctosigmoidectomy	Ca. Rectum	Good	Bil. Colic
KD	79	Sigmoidectomy	Carcinoma	Expired	Myo. Insuf.
MG	79	Hip Pinning	Fracture	Good	Bil. Colic
AH	65	Colostomy	Ca. Rectum	Satis.	Cystitis
WJ	62	Gastroenterostomy	Pyloric Obstruction	Good	Evisceration
CL	58	Cholecystostomy	Pancreatitis	Good	
		Comm. Duct. Expl.	Stones	Good	Atelectasis
ML	68	Hip Pinning	Fracture	Good	.....
WL	80	Bowel Resection	Meckel's Diverticulitis	Expired	Myo. Insuf.
				9th. POD	Embolism
JM	73	Bilateral Herniorrhaphy	Herniae	Good	.....
LP	52	Bilateral Herniorrhaphy	Herniae	Good	.....
RR	59	Subt. Gastrec.	Ulcer-Obstruction	Good	Thyrototoxicosis
ER	67	L. Lum. Sympath.	Arteriosclerosis	Good	.....
		Hip Pinning	Fracture	Good	.....
		Amputation, L	Peripheral Vascular Disease	Good	.....
TM	68	Amp. L. Forearm	Crush Injury	Good	.....
FH	70	Appendectomy	Appendicitis	Good	Phlebothr.
FH	69	Prostatectomy	Benign Prostatic Hypertrophy	Good	.....
AH	60	Herniorrhaphy	Hernia	Good	.....
MH	74	Radical Breast	Carcinoma	Satis.	.....
KM	63	Cholecystectomy	Cholelithiasis	Good	.....
MO	63	Total Panhysterectomy	Ca. Fundus	Good	.....
WN	65	Prostatectomy	Benign Prostatic Hypertrophy	Good	.....
MO	65	Cholecystectomy	Cholelithiasis	Good	Ileus
ES	69	Amputation Leg	Arteriosclerosis	Good	.....
GR	69	Colostomy	Ca. Rectum	Exp. 19th POD	Peritonitis
SW	75	Prostatectomy	Benign Prostatic Hypertrophy	Good	.....
LU	74	Cholecystectomy	Hydrops		
		Choledochotomy	Choledocholithiasis	Good	.....
HG	87	Thigh Amputation	Arteriosclero.	Good	Dementia
MW	63	Hepatic & Splenic Art. Lig	Cirrhosis	Good	.....
MJ	62	Cholecystectomy	Cholelithiasis		
		Choledochostomy	Choledocholithiasis	Good	.....
BW	66	Cholecystectomy	Cholelithiasis		
		Subt. Gastrectectomy	Linitis Plastics	Good	Pul. Edema
MJ	64	Cholecystectomy	Cholelithiasis	Good	.....
CB	67	Sigmoidectomy	Diverticulitis	Good	.....

a previously undiagnosed pancreatitis. Results in these three were good. The others were thoroughly evaluated, and, prior to surgery were restored to as near normal physiology as possible by whatever means was indicated. Three deaths occurred, a mortality rate of 6.1%, all as a result of postoperative complications. Myocardial insufficiency with failure occurred in a 79 year old woman whose sigmoidectomy was performed because of an obstructing carcinoma of the sigmoid. The second occurred in an 80 year old man who developed partial obstruction and a pelvic abscess following Meckel's diver-

iculitis, in whom a bowel resection was necessitated. An arterial embolism occluded the right iliac artery thirty-six hours post-operatively. Embolectomy was performed, and the patient heparinized. Subsequent hemorrhage, forty-eight hours later was controlled, but myocardial insufficiency with failure, occurred and he expired. The third death occurred on the nineteenth post-operative day, in a 69 year old man with metastatic carcinoma from the rectum when he developed peritonitis following a colostomy. A 52 year old man is included in this group because of the presence of earlier than usual

geriatrics changes, including a low cardiac reserve, mild hypertension, and moderate arteriosclerosis.

It was pointed out earlier that alertness to detail and active treatment was more necessary in the geriatric patient in order to cope with the increased number of complications. As evidence of that need, I point out that 31.4% of this group required diagnosis and treatment of other than their primary disease.

#### SUMMARY

A brief review of literature has been presented and the increasing geriatric population noted.

Elective surgery in the middle age group may be a more greatly utilized prophylaxis of geriatric emergencies and catastrophes.

Restoration of normal physiology via blood, plasma, water, electrolytes, antibiotics, digitalization, and physical support is emphasized.

33 cases are presented.

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## WHAT SHOULD WE DO WITH THE AGED?

Societies and civilizations past and present have accepted the problem of the aged in a variety of ways. We all know of the veneration of the elderly by the Chinese. We also know the dangers which are attached to veneration and adherence to those things which are old to the exclusion of those things which are new. At the other pole of attitude toward the elderly is that of the Laborador eskimo who quietly disposes of his old folks or of the Northwestern eskimo who expects his old folks to go on a long walk in a snow storm and become lost or of the Hottentot who builds a small hut for his elderly parents, places therein a small quantity of food and then moves on. In the United States we merely ignore old people.

While we are ignoring old folks, medical science continues its battle against death and continues to prolong life so that the absolute number as well as the relative number of elderly people increases steadily. More and more we find it necessary to work hard at the job of ignoring the problem of the aged. The aged are be-

coming so numerous and such an economic burden that it is very difficult to continue to ignore them. Then too, our Judeo-Christian tradition causes us to feel guilty, as much for acts omitted as for acts committed. Thus we find ourselves in a position of being forced to recognize there is a problem and forced to try to do something about it. Roy C. Knowles, M.D., Sioux Falls, S. D., *Father Time Presents the Medical Profession with a Problem. S. D. J. O. M., January, 1954.*

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Mental institutions in many of the states have developed programs for the control of tuberculosis among their patients. These programs, while differing in detail, are alike in their stress upon the importance of case finding and segregation in the prevention of tuberculosis, and their success is justification of the emphasis placed upon these features of tuberculosis control. Because of the excellent results obtained by long-term tuberculosis control programs in these states, it is difficult to understand their absence in others. Editorial, Julius Katz, M.D., NTA Bulletin, Feb., 1954.

# Injuries to the Ureter of Interest to the General Surgeon

Gerald F. Whitlock, M.D.  
Urbana

Operative injuries of the ureter continue to occur as complications of abdominal and, especially, pelvic operations. If the true incidence were known, the frequency of such injuries probably has increased in the last fifteen years because of the greater popularity of total abdominal hysterectomy (as apposed to supracervical hysterectomy), vaginal hysterectomy, and the Wertheim type of radical hysterectomy. The majority of ureteral injuries occur during gynecological operations, although occasionally they occur with right or left colon resection and abdominoperitoneal resection of the rectum.

Ureteral injuries are serious. The majority are not recognized at the time of surgery. The resultant effects, if unrecognized, are such as seriously to endanger the patient's life. Distressing ureterovaginal fistula or loss of a kidney are frequent end results of mismanagement.

*Types and Causes:* One or both ureters may be injured by (1) cutting (complete or incomplete section), (2) clamping, (3) ligation, (4) avulsion, (5) partial suturing, (6) extensive dissection with disturbance of blood supply, and (7) partial occlusion or kinking from late periureteral adhesions.

The two operations in which ureteral injury is most likely to occur are complete abdominal hysterectomy with removal of intraligamentous tumors and radical abdominal hysterectomy for cancer of the cervix.

The ureter is more subject to injury when its normal course has been altered by pelvic disease. This is likely to occur in (1) myomata of the cervix, (2) intraligamentous myomata, (3) endometriosis, (4) chronic adhesive inflammatory disease, (5) ovarian malignancies, (6) post-irradiation pelvic fibrosis, and (7) cancer of the cervix.

## RESULTS OF UNRECOGNIZED INJURIES

*Partial section of one ureter or transfixion of a ureter with a suture* with subsequent urinary leakage usually results in a ureterovaginal or uretero-abdominal fistula. Local infection is likely. The fistula may heal spontaneously but only at the cost of a non-functioning kidney because of ureteral stricture, hydronephrosis, and renal destruction.

*Complete section of one ureter* usually results in local abscess and/or widespread infection from urinary extravasation. If the patient lives, fistula formation will occur.

*Complete section of both ureters* results in extravasation, general sepsis and death, if unattended.

*Ligation of one ureter* may result in symptomless atrophy of its kidney or may result in symptomatic hydronephrosis or pyonephrosis. Undoubtedly ligation has occurred many times without ever being recognized because symptoms may not occur.

*Bilateral ligation* results in immediate, complete anuria and is followed by uremia and death, if unrelieved. In complete anuria following hysterectomy, the surgeon should think first of bilaterally occluded ureters before considering reflex renal suppression, transfusion reaction, or lower nephron nephrosis as the cause. Diagnosis is verified by ureteral catheterization.

*Clamping of a ureter* may result in no permanent injury or may be followed by fibrosis with stricture formation and subsequent hydronephrosis or pyonephrosis. If localized thrombosis and necrosis occur, leakage may follow with abscess formation or fistula.

In some instances the *ureter is traumatized and devitalized by extensive dissection* with resultant late necrosis and fistula formation. This is most likely to occur in the radical pelvic evisceration techniques for treatment of cancer.

*Partial occlusion of the ureter* with kinking

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Read at the Illinois State Medical Society meeting,  
Section on Surgery, Chicago, Illinois, on May 13, 1952.  
From the Section on Urology, Carle Memorial Hospital and Carle Hospital Clinic, Urbana, Illinois.

or stricture may follow unanatomical suturing, peri-ureteral adhesions, or irradiation fibrosis. This results in a slowly developing dilation of the upper urinary tract with its vulnerability to infection and degeneration of the kidney.

Spontaneous healing of a ureterovaginal fistula after treatment by expectant procrastination almost always eventuates because of a non-functioning kidney above. Closure of the leak does not mean that the patient is well with two good kidneys.

#### TREATMENT

*Preventive treatment:* If the surgeon expects to encounter intra-ligamentous tumors, endometriosis, extensive pelvic inflammatory lesions, or adhesions, he would be wise to place catheters up both ureters before operation to serve as identifiable guides during the surgery. Of course, if he is over-zealous with his clamps, a crushing injury to a ureter containing a catheter might well be more injurious than to an empty ureter.

Careful surgery is the only real preventive. It would not be too much to ask the pelvic surgeon to identify both ureters during the operation and to make sure, as far as possible, that ureteral injury has not occurred before he closes the wound.

In abdominal or vaginal hysterectomy, the bladder should be well freed from the anterior surface of the fundus and cervix and retracted anteriorly. This will help carry the ureters away from the area of the uterine vessels.

When working posteriorly in abdominal hysterectomy, it is well, after cutting across the peritoneum posterior to the uterus at the junction of the utero-sacral ligaments, to carefully push the severed tissues down to the floor of the pelvis. This maneuver also carries the ureters out of the area where uterine artery clamps are applied.

In both abdominal and vaginal hysterectomy it is, of course, important to stay as close to the body of the uterus as possible in sectioning the broad ligaments.

In resecting the ovary, it is important to identify and protect the underlying ureter before the infundibulo-pelvic ligament and ovarian vessels are clamped and cut.

In any procedure in which the ureter must be dissected from its bed, it is advantageous to

leave a strip of peritoneum attached along its entire course. This helps prevent interruption of the ureter's delicate blood supply.

#### TREATMENT OF RECOGNIZED INJURIES

*Severed ureter:* If the ends of a severed ureter can be brought together without tension, ureteral anastomosis is my procedure of choice. The traumatized ends should be trimmed obliquely. A No. 8 ureteral catheter or similarly sized length of polyethylene tubing should be threaded up the ureter into the renal pelvis and the other end passed down to coil in the bladder. The oblique ureteral ends are then united with four or five interrupted sutures of #0000 chronic catgut on a swedged needle over the splinting catheter. All manipulations of the cut ends of the ureter should be carried out with fine catgut traction sutures rather than with metal instruments to avoid further trauma. Dissection of the ureter from its normal bed should be minimal. The peritoneum must be closed water tight. Extraperitoneal drainage through a stab wound should be established. The end of the rubber drain should not be in close contact with the anastomosis. The splinting tube helps prevent leakage and late contracture of the suture line. Its end in the bladder should be pulled to the outside with cystoscopic forceps after the operation. It should be anchored to the thigh or to an indwelling Foley urethral catheter. The patient can void around the splinting catheter without difficulty even if a urethral catheter is not left in place. If not anchored or if left in the bladder, the splinting catheter will gradually be milked out of the ureter by peristalsis. It can be removed after ten to fourteen days. The extraperitoneal drain may be left a day or two longer to take care of any urinary leakage from the anastomosis.

The patient should be followed by intravenous urography to be sure that no stricturing with dilatation of the upper tract is taking place. The ureter may be calibrated for stricture by ureteral catheterization postoperatively. If a stricture is present, ureteral dilatations will be necessary.

Another satisfactory method of handling the severed lower ureter is re-implantation into the bladder. Ureterocystotomy is possible only when the upper ureteral segment will reach the bladder without undue tension. The anastomosis can be carried out satisfactorily from outside the bladder by utilizing a method of mucosa-to-mucosa

suturing. The end of the ureter is made spatulate by incising the end longitudinally for 1 to 1½ centimeters as advocated by Nesbitt. This increases the lumen by 3.1416 times (pi). A traction suture is then placed in the "V" of the incised ureter to aid in manipulating the ureter and to act as the primary suture in the weakest point of the anastomosis. A stab wound similar in size to the length of the split in the ureter (1-1½ centimeters) is then made at a convenient location in the bladder wall, preferably near the base. The ureter is then sutured to the mucosa of the bladder with closely placed interrupted sutures of #0000 chronic catgut on an atraumatic needle. If a running suture is preferred, it should be done with two separate sutures, one on either side to avoid the purse string effect of a single encircling suture. Three or four anchoring sutures may then be taken between the adventitia of the ureter and the muscularis of the bladder.

Uretero-sigmoidostomy should be done only if the two other methods of handling the cut ureter are impossible. The end results of uretero-intestinal anastomosis are not universally good because of the well-known complications of leakage, stricture formation, recurrent pyelonephritis and derangement of the chemical balance of the body.

If the condition of the patient is such as to preclude the extra time involved in the foregoing methods of repair, the cut end of the ureter may be quickly brought out through a stab wound in the abdominal wall as a cutaneous ureterostomy. This offers temporary preservation of renal function until such time as a more satisfactory type of repair can be carried out.

In almost no instance should the cut ureter be purposely ligated and dropped back into the wound. Ultimate loss of the kidney is certain, either by atrophy or hydronephrotic destruction. If the patient is lucky, she will lose only a kidney — if the surgeon is lucky, she will do so asymptotically. If the surgeon has a really good excuse for so treating an injured ureter, he had first better make certain that there is at least a palpably normal kidney on the other side.

*Ligation or clamping of a ureter* does not usually result in permanent injury if the ligature or clamp is promptly removed. In either event extraperitoneal drainage should be established and postoperatively a ureteral catheter should be

placed in the ureter and left for a week. The result is usually a normally functioning ureter and kidney.

#### UNRECOGNIZED INJURIES

The majority of ureteral injuries are unfortunately not recognized during the operative procedure. These late-developing complications are serious and are difficult to remedy. Each condition must be handled on its own merits.

*Bilateral ligation:* If bilateral ureteral occlusion by ligation is suspected in the anuric patient, the surgeon is faced with two alternatives of management, either immediate deligation or bilateral nephrostomy drainage. One or the other should be done as soon as the diagnosis is certain. Bilateral occlusion should first be verified by cystoscopy and ureteral catheterization.

Deligation is a very difficult and hazardous procedure. The wound must be reopened. Troublesome bleeding is almost certain. Even within 24 hours the edema and induration of the pelvic tissues make for technical difficulties. The mortality rate is high.

Bilateral nephrostomy is probably attended with less mortality. The injured ureters may then be repaired by bilateral uretero-cystotomy at a later time when the pelvic tissues have been restored to normal. Moreover, the ligated ureters may later spontaneously regain patency as the catgut absorbs. This may be abetted by ureteral catheterization and thus further surgery may be obviated.

*Unilateral ligation* may be handled by temporary nephrostomy or T-tube ureterostomy with later definitive repair.

In *uretero-vaginal fistula*, urologic study should be carried out as soon as the fistula is evident to determine the best means of preserving kidney function. Differentiation between vesico-vaginal and uretero-vaginal fistula can be made by cystoscopy and retrograde pyelography or by the instillation of a colored dye into the bladder with gauze in the vagina.

If repair is carried out early, before renal destruction takes place, re-implantation of the ureter into the bladder may be possible. In late fistulas a nephrectomy is usually necessary for cure.

#### CASES

In the past six years there have been three known ureteral injuries in our clinic. One was

complete severance of the upper one-third of the right ureter during a right colectomy for carcinoma of the colon. The other two were complete sections of the left ureter at the pelvic brim. Both occurred in resection of the ovary in extensive endometriosis. In both instances the ureter was adhered to the mass. In all three cases, the injury was recognized at the operating table and repaired immediately by ureteral anastomosis according to the above-described technique. In all three instances the final end result was excellent. No stricture occurred and postoperative intravenous urograms disclosed normal appearing kidneys and ureters.

## CONCLUSIONS

The plea is tri-fold:

(1) Prevention of ureteral injuries, if possible. This can be accomplished only by careful dissection, anatomical knowledge, and a degree of forethought.

(2) Recognition and immediate appropriate repair at the operating table, when prevention fails. The surgeon should search for ureteral injuries before closing the abdomen even as he requests a sponge count.

(3) Prompt and definitive diagnostic and reparative measures postoperatively, if recognition fails. Only in this way can destruction of the urinary tract be avoided.

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## THE CAUSE OF HYPERTENSION

There are times when the strident conflicts of investigators, the rise and fall of theories, and the babel of unsorted evidence create such a sense of confusion in a field that an atmosphere of frustration and despair prevails in which no one believes anything; this has happened to some extent in hypertension. Yet somewhere between the extreme skepticism, both of the very young and of the old and tired, and the transient enthusiasms of the protagonists of this theory or that remedy, lies a middle ground of achievement or even agreement. It is generally agreed, for example, that the cause of ordinary hypertension is narrowing of the terminal vascular bed of the systemic circulation, especially the arterioles. It also is generally believed, although with some dissension, that there are three major causes of

such narrowing. One is increased discharge via the sympathetic nervous system. Another is increased vasomotor tone produced either by circulating substances or by metabolic changes. A final cause is structural changes in the vessels themselves, frequently influenced — at least, in part — by the first two factors. What is more, in the ordinary hypertensive the neurogenic factor usually is the first and, as believed by some, the initiating factor in the process. The humoral or metabolic element contributes later, when the kidneys participate in the disease. This factor accelerates the disease by increasing vasomotor tone; and, finally, the structural changes in the arterioles produced in part by these influences turn the screw tighter. *Milton Mendlowitz, M.D., The Treatment of Hypertension with Drugs. Ann. Int. Med. Nov. 1953.*

## CASE REPORTS



### Cervical Pregnancy

**W. H. Cave, M.D., F.A.C.S.**  
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Cervical pregnancy is an unusual complication to encounter and certainly the clinician, unless by some good fortune has read or heard of case reports, is most apt to be caught in a situation in which he is not exactly sure with what basic pathology he is dealing. It may have a rather dramatic onset of hemorrhage leaving little time for considered contemplation or it may be a slow insidious type of bleeding leaving the impression that one is dealing with the garden variety abortion only to be suddenly shaken by the onset of a severe hemorrhage.

There is considerable confusion as to what constitutes cervical pregnancy. From the name one would infer that it means a pregnancy in the cervix itself but it is well known that under normal circumstances the cervix is not capable of supporting the nidation of the ovum after fertilization and the counter part of this condition would be a tubular pregnancy which results in either tubular abortion or rupture. While cervical pregnancy is similar in that it is located at an ectopic site the results are reverse to that of the tubes in that abortion is far more common than is an actual rupture

of the cervix. Schneider<sup>1</sup> has aptly labeled the condition as "Distal ectopic pregnancy."

However most confusion exists as to what constitutes the entity. It has been stated that there is no such condition. Cervical pregnancy was first described by Rokitansky in 1860<sup>2</sup> and the first term cervical pregnancy was described by Tarnier<sup>3</sup> in 1887. There is no way to determine whether or not a viable child has resulted from such a pregnancy but it is extremely doubtful. In all probability the majority are aborted as reported in the literature in the early weeks of gestation.

Rubin<sup>4</sup> in 1911 in reporting a case of his own outlined four criteria necessary to substantiate a diagnosis of cervical pregnancy. The sharp point of differentiation must be made from the low lying placenta of placenta previa. Rubin's criteria are both microscopic and gross appearance. First there must be cervical glands opposite the placental attachment, second the attachment of the placenta to the cervix must be intimate, thirdly the placenta must be below the uterine arteries and the anterior and the posterior peritoneal reflections and lastly no fetal elements must be in the corpus uteri. These points are well made to avoid confusion from

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From the Hedges Clinic.

the possibility of a corpal abortion lying in a dilated cervical canal. Actually in the majority of cases the diagnosis has been made at the operating table with substantiation microscopically. But above all it must be felt and seen to be sure of the true nature of the condition so that in most reported cases the diagnosis is a clinical rather than a pathological one.

In 1945 Suddiford<sup>5</sup> made an excellent and a rather extensive review of cervical pregnancy, reporting two cases of his own. He stated that the condition had been given but scant attention in the literature of this country, having found only one case reported since 1900 which one would assume to be that of Rubin's. Also he found no mention at all of the condition in two of the more widely used text books of obstetrics in this country and a denial of its existence in a third. A similar situation was encountered by this author some eight years later. Practically all cases were reported in foreign literature and all consisted of a report of either one or two cases. Baptisti<sup>6</sup> stated in all probability the majority of obstetricians will never encounter one and from the reported experiences of others it is just as well that they don't. Suddiford found 28 reported cases and added two of his own. This statement is however at variance with European reports<sup>7</sup> who mention a varied number between forty and fifty. Baptisti this year reported seventeen including two of his own since 1945 when Suddiford published his paper. In any event it is an unusual condition but because of its severity when encountered it is felt that all cases should be reported.

Of the 28 cases reported by Suddiford there were six deaths or a mortality figure of 21.4 per cent. Of the 17 Baptisti reported after that date there was one death giving only 5.8 per cent mortality. The 17 received a total of 11,000 cc. of whole blood but the one fatality had only received 500 cc. of blood. Only one of the 28 cases reported by Suddiford had received blood which leads one to wonder that there were only the six deaths. Certainly there has been no actual improvement in the handling of a cervical pregnancy but there is a far better concept of the treatment of an acute anemia due to blood loss as well as the numerous blood banks now operating.

The etiology of this condition is unknown. There is much evidence, if one can follow the prolific philosophic deductions upon the part of European authors as its cause, but practically no facts. As Suddiford has stated, about the only thing in common the victims of a cervical pregnancy have is the tendency to be in the older age group. It has been reported from 17 to 46 but the average age is about 35. The majority abort in the early weeks of pregnancy, there having been reports where there was no history of an ammenorrhea. There are a few reported as term pregnancies<sup>8</sup> but this by the very anatomic nature of the cervical region is somewhat doubtful. It would seem that a cervical pregnancy would follow the general rule of a pregnancy in any ectopic site and abort at an early period. Parity does not seem to be a factor. Of the 17 cases reported by Baptisti there have been four subsequent term pregnancies so that in the child bearing period every effort should be made to conserve the uterus.

It is very doubtful that the diagnosis is made except at the operating table. The usual history is that of early bleeding in pregnancy, 8 to 12 weeks, which is painless. It may be of only moderate proportions or very severe and ushered in with an abrupt onset of an almost exsanguinating hemorrhage. Depending upon the length of gestation there may or may not be a rather large cervical opening and the external os may admit the finger tip. If the bleeding has been only slight the cervical os is closed. The appearance of the cervix is not diagnostic, and has been mistaken and treated for carcinoma of the cervix.<sup>9</sup> After the diagnosis has been established, with the aid of hindsight one is able to get a visual picture of the situation. The following case history is a rather classic example of more or less stumbling into a cervical pregnancy and with a great deal of luck coming out with a living patient.

A 45 year old woman, Grava IV, Para III, was admitted to the hospital June 6, 1953 because of a profuse vaginal hemorrhage beginning three hours prior to admission. She had always been healthy but for about the last year her periods had been irregular in that she would miss from one to two months. She

was about two weeks overdue as best she could remember but thought nothing of it because she had missed periods for the last year. She was awakened at 4 A.M. the day of admission, her bed soaked with blood and when she got up it seemed to pour from her vaginally. When she lay down again it would subside somewhat but about four hours after the initial bleeding she began to cramp a little and profuse bleeding again started. She was immediately hospitalized. Upon admission she appeared pale and clammy but the blood pressure was 110/70 with a pulse of 96. She was having rather active vaginal bleeding. Her initial R.B.C. was 3.3 million and R.B.C. 10 gms. Urine and differential blood count were non contributory. As there was rather brisk bleeding a speculum examination was not done. Upon bimanual examination there was a soft spongy mass felt in the cul-de-sac extending down to the cervical os, and over to the left a firm hard moveable mass was felt. After examination the bleeding was even more brisk and it was felt that blood should be started and an immediate laparotomy carried out in that she was forty-five years of age and there seemed little point in a salvage of female organs but more important that the hemorrhage be controlled. Quite frankly there was no good pre-operative diagnosis made although several were entertained. The most likely considered was a sub-mucus fibroid; pregnancy receiving little consideration because of her past history and her age.

She was given blood and under cyclopropane anesthesia, a low mid-line incision was made. A normal appearing, firm although somewhat enlarged uterus was seen perched upon a bulging mass below the peritoneal reflections. This was the firm mass that had been felt to the left on bi-manual examination. As yet the operator was entirely ignorant of the true nature of the situation but felt that the bleeding should be controlled and in order to see what caused the cervical bulge a total hysterectomy was started. After freeing the uterus and believing that the cervix was coming along also, a cut in what was thought to be a vaginal cuff was made and from below came old blood, clots and macerated products of conception. The uterus was removed and upon inspection there

was no cervix with it. Actually a thin cervix had been cut across where considerable active bleeding was encountered. The vaginal branches of the uterine arteries were secured and the cuff closed. A finger inserted into the cervical canal disclosed a ballooned out cavity, thin walled, containing an aborted pregnancy. She received 1500 cc. of blood. Her post-operative course was uneventful and she was discharged on the fifth post-operative day. A six week check up disclosed a well healed abdominal wound and a normal appearing cervical stump. The pathological description was grossly that of a uterus amputated above the cervix. Microscopically there was described from sections of the lower segment hyperplasia and occasional cystic dilatation of the cervical glands with a marked decidual reaction in the stroma and wide areas of degeneration. The pathologists were not present at surgery nor informed of the findings at surgery and the pathological diagnosis was post-partum uterus. However, both grossly and microscopically, the criteria as laid down by Rubin were fulfilled. Therefore the diagnosis of the condition was a clinical one with pathological confirmation. It was only after a review of the literature that the full import of the condition was realized. It would seem to the author that a pathological diagnosis of this condition would be very difficult to make unless the pathologist were present at surgery or afterwards informed of the appearance and nature of the findings.

#### SUMMARY

Another case history of a cervical pregnancy has been added to the small number already described. Only by good fortune was this case brought to a satisfactory conclusion as there was no thought of a cervical pregnancy until the uterus had been removed and examined at surgery. Other physicians may very well encounter the condition so that it is felt that case reports of this type will serve to reiterate from time to time certain rather infrequent emergencies that may be handled in an orderly and knowing manner. It is the impression of the author that there is no definite way to handle a cervical pregnancy and each case must be evaluated carefully to be brought to a successful conclusion. In retrospect this case

would have been handled just as it was even though there was not an exact pre-operative diagnosis.

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## THE MEDICAL RECORD IN COURT

The medical record is an important aspect of the proof of a plaintiff's or defendant's case. Its inherent importance is enhanced by the fact that usually the hospital or doctor is not interested in the result of the litigation and is in the same relative position, therefore, as the innocent bystander at an accident. Since the latter is not involved in the controversy, his word is thought by jurors who have no comprehension of the fallibilities of even honest testimony to be entitled to more credence and weight than the stories of the participants in the litigation. The hospital and physician and its or his records bear the same exalted position in this regard as the testimony of the innocent and disinterested bystander.

Factually, the record may be important in several ways. In the first place, it contains a source of description of the nature and extent of the plaintiff's injuries. These are often of importance; for example, matters which do not seem important from the point of view of therapy are often of importance from the point of view of the litigation. That is to say, to the doctor, the number of stitches taken in a suture is perhaps of no great importance but it impresses the jurors to have testimony that the repairs upon the victim's anatomy required 34

stitches. Moreover, the locus of the injuries often tends to refute and rebut or to corroborate the victim's story of where or how he was hurt.

The medical record also is of importance because it serves as a guide to prognosis, which often is an important aspect in the proof or a plaintiff's or a defendant's case. The plaintiff is entitled to recover all of the damages which he has suffered as a result of the acts of the defendant and included in these are the damages which, if these can be proved by a preponderance of the evidence, the plaintiff will suffer in the future from injuries sustained. Hence, questions of prognosis often are involved in determining the amount of the verdict or judgment. These forecasts of prognosis derived from the hospital or doctor's report are at times inadequate or insufficient to prove future damages and the plaintiff or defendant, therefore, is required by the necessities of the situation to present additional medical evidence. Often this takes the form not only of the clinical examination of the party concerned and the rendering of an opinion based upon that examination but also, on hypothetical questions asked of the physician expert on the basis of facts adduced from the hospital record. *Gerald W. Harrington, The Medical Record in Court. Rhode Island M. J. Oct. 1953.*

# CASE RECORDS OF THE COOK COUNTY HOSPITAL

KARL MEYER, LEO M. ZIMMERMAN, DEPT. EDITORS

## The Problem of Postoperative Common Duct Stones

**Frank V. Theis, M.D., John Sylvester, M.D. and Edward Schnell, M.D.**  
**Chicago**

In spite of every precaution to remove all common duct stones at operation, some may be overlooked. This unexpected finding on postoperative cholangiograms usually calls for a second major operation. However, other means for removal of the elusive stones by simple, effective and safe nonoperative procedures have been reported in the literature. Two such cases have been treated unsuccessfully by the most popular recommended procedure; one case is reported because evidence of liver damage followed careful irrigation of the common duct with ether.

Mrs. F. D., age 62 years, was admitted to the Cook County Hospital on February 11, 1953, because of jaundice. Two months previously a severe constant pain had developed in the right upper quadrant of the abdomen which had lasted for three or four days and had been followed by persistent yellow color of the skin, clay colored stools and dark urine. About 18 months prior to this episode a similar attack of pain had oc-

curred and lasted for one week but there was no change in color of the skin, stools or urine. There had been no colicky pain, anorexia, melena, food dyscrasia or loss in weight. Otherwise history was negative.

Physical examination was essentially negative except for the jaundice and abdominal findings. The temperature, pulse, respiration and blood pressure were normal. The liver was palpated three fingers' breadth below the costal margin; its edge was firm and slightly tender. The gallbladder and spleen were not palpable.

Laboratory examination revealed benzedine-negative, clay colored stools; urine contained four-plus bile with no urobilinogen on six occasions, and two-plus urobilinogen for two days before operation; blood counts, serology and blood nonprotein nitrogen were normal; liver tests showed a markedly elevated icteric index (101) and serum alkaline phosphatase (21.2); liver function tests were not impaired; and x-ray studies of chest, abdomen and gastrointestinal tract were negative.

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Surgery was performed on February 25, 1953. Through a right subcostal incision the gallbladder and common duct were exposed. The gallbladder was enlarged and thickened but no stones were palpated in the gallbladder or dilated common duct. Except for fibrinous adhesions around the gallbladder there were no other pathologic findings. The pancreas was not enlarged and seemed to be normal. The common duct was opened and found to be filled with multiple soft, kernel to pea-sized stones and a large amount of "sludge". The stones were of mixed bile and cholesterol type and were removed by scoops and saline irrigation. A probe was passed distally into the common duct and the sphincter of Oddi dilated to six millimeters. The thickened gallbladder was removed and the T-tube reinserted in the common duct. The first cholangiogram was made through the T-tube on March 17, 1953, revealing a delayed passage of dye into the duodenum and a filling defect at the distal end of the common duct (Figure I). Repeat cholangiogram on March 30, 1953, showed the same findings. However, the patient was clinically unobstructed and tolerated continual clamping of the tube. The elevated icteric index and serum alkaline phosphatase returned to normal. Convalescence was uneventful.

On April 20, 1953, intravenous injections of decholine (5cc. daily) were started in an attempt to flush out the common duct. Eight days later another cholangiogram revealed no change. It was decided that the procedure used and described by Strickler<sup>14</sup> and others, might be effective in dissolving or expelling the stones from the common duct.

The following program was adhered to strictly twice daily for 24 days:

1. The T-tube was aspirated.
2. Nine cc. of 1.5 per cent metycaine were injected into the tube and clamped for ten minutes.
3. A mixture of 3.5 cc. ether and 1.5 cc. 95 per cent alcohol was injected and the tube compressed cautiously with finger pressure. Intermittently, every 45 to 60 seconds, the tube was opened to prevent excessive pressure from being built up as a result of vaporization of the ether. Fifteen minutes following the

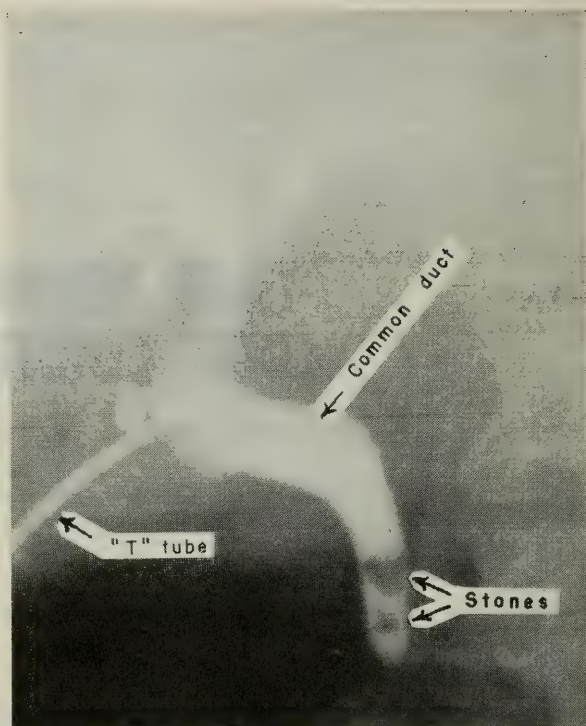


Figure 1

**Postoperative cholangiogram.** The contrast media was injected through the "T" tube three weeks after surgery as a routine procedure before the tube is withdrawn. There was no evidence of biliary obstruction despite the roentgen findings of stones in the distal part of the common duct. Repeat cholangiogram after 24 days of irrigating the common duct were unchanged. Surgical removal of the stones was required.

injections all contents of the tube were aspirated.

4. Five cc. of sterile mineral oil were injected and the tube clamped.

The patient experienced no severe pain at any time; occasionally a slight dull cramping pain in the epigastrium occurred for a few seconds.

Repeat cholangiograms revealed some questionable decrease in size of the stones. Since progress seemed to be very minimal, surgical removal of the retained stones was considered necessary. At this time the liver profile and all blood chemistries were normal except that the serum alkaline phosphatase had increased from 3.8 Bodansky units to 22.8 units following ether irrigations. This evidence of liver injury, influenced the decision to remove the stones surgically.

On June 24, 1953, the common duct was reexplored through the site of the T-tube. A small amount of dark colored gravel was removed from the distal end of the common duct

which then was irrigated with large amounts of saline. The liver appeared normal. A probe was passed into the duodenum after opening the duodenum to guide the instrument. The T-tube was reinserted. Convalescence was uneventful.

The stones appeared to be a mixture of cholesterol and bile pigments. Chemical analysis of the stones showed cholesterol and bile pigment but no calcium. The stones were placed in an ether-achohol solution for six months; disintegration of the larger fragments occurred but there was no apparent dissolution.

Further cholangiograms through the T-tube showed rapid emptying of the common duct into the duodenum. No shadows were visible. Prolonged clamping of the tube produced no clinical symptoms and the tube was removed after three months. The patient has remained well at the end of 14 months. Five months were required for return of normal serum alkaline phosphatase (Table I).

## DISCUSSION

Surgery for retained common duct stones is frequently a difficult and hazardous procedure. Consequently, many surgeons have used and advised various nonoperative methods for dissolving or expelling the stones. Ether irrigations of the common duct are most widely advocated and, as early as 1891, Walker<sup>17</sup> reported the successful use of ether and glycerine, introduced via a sinus tract into the gallbladder.

Priham<sup>9</sup> (1935), was the first to advocate ether irrigation into the common bile duct. He reported (1947) 51 successful cases<sup>11</sup>. With such success, this method deserves consideration. From 0.5cc to 1cc of ethyl ether is injected

into the T-tube. He stressed the importance of drop by drop instillation and aspiration when the patient complained of pain. Injection of one to two cc of liquid paraffin daily is continued for one week. Pribam's rationale was that ether dissolves the "cholesterol kernel" and that liquid paraffin transforms the stones into a soft pulp for easier passage through the ampulla of Vater.

In 1937, Walters and Wesson<sup>14</sup> reported a case of stone in the ampulla of Vater. They used a 5cc mixture of 2/3 ethyl ether and 1/3 ethyl alcohol. Simultaneously, an inhalation of amyl nitrite was given. They believe that ether causes fragmentation of the stone, that expulsion of the fragments is produced by increased intraductile pressure as a result of ether vaporization and that amyl nitrite relaxes the sphincter of Oddi to facilitate passage of stones. Their two later cases were treated unsuccessfully by this method<sup>15</sup>.

Raffl<sup>13</sup> reported that a pure cholesterol stone 1 cm. in diameter will dissolve in ether in one hour. However, when impregnated with even a trace of calcium the solubility is markedly decreased. He pointed out that 1cc of ether will evaporate at 38° C and 760 mm. mercury pressure to form 222.1cc of vapor. Consequently, he recommends immediate release of pressure within the common duct. He accomplished this with a two-way catheter. In dogs he showed that very little inflammatory reaction occurred in the gallbladder, ducts or liver, provided there was an "immediate exit". For this reason Raffl designed a two-way catheter for decompression.

TABLE 1. BLOOD CHEMISTRY DETERMINATIONS.

[illegible]

Probstein and Eckert<sup>12</sup> studied the possibility of damage produced in dogs by ether instillations; they found no pathological changes in the liver. However, in the extrahepatic biliary tract and larger bile ducts in the liver, necrosis and sloughing of the epithelial lining was noted. Strickler<sup>14</sup> believes this is not sufficient contraindication for the use of ether because the amount employed in dogs was relatively large as compared to that used in humans. Furthermore, injections were made directly into the gallbladder and were not followed with instillation of oil.

More recently, Best, et al<sup>4</sup>, injected either chloroform or ether through a T-tube implanted in the common duct. Microscopically, no significant damage was found in the ductile tissues. However, central lobular liver necrosis was observed in the experimental group; the necrosis was more constant and severe with the chloroform. These injections were equivalent to 28cc of chloroform (at each instillation) in a 70 kg. man. The absence of clinical evidence of harmful effect of ether is illustrated by a patient of Amsterdam and Sterling<sup>1</sup>; the patient himself instilled ether through a cholecystostomy tube for 11 months without apparent damage.

Failure and dissatisfaction with the Pribam method has been attributed to either too short a trial or the incidence of pain and shock (due to sudden increase in intraductile pressure). This led other investigators to use drugs to relax the sphincter of Oddi i.e., amyl nitrite or nitroglycerine. Walters and Wesson had one successful experience with this method<sup>15</sup>.

Best<sup>3</sup> gave nitroglycerine three days prior to irrigations; in addition, two drams of magnesium sulfate were given twice daily and at bedtime an ounce of olive oil or thick cream. The common duct was then irrigated daily through the drainage tube or fistula with warm saline and this was followed with 10 to 30cc of warm sterile olive oil. Decholin, three to five 3-3/4 grain tablets, four times daily, was given to increase and maintain the flow of bile in the common duct so that stones would be expelled. Best cautioned against the use of dehydrocholic acid with complete obstruction or any degree of jaundice because of possible liver damage. According to Best, in later reports<sup>4,5</sup>, the use of

alcohol in combination with ether actually slows the breakdown of stones; greater intraluminal pressure will be produced with the ether solvent alone.

Goldman, Jackman and Eastman<sup>8</sup> advise solution G, a renal stone solvent, as chemically effective for bilirubin stones. They reported two successful cases. In vitro, solution G did not dissolve gallstones but they suggested that the irritant action of the solution may stimulate sufficient muscular activity to dislodge a stone. Solution G is composed of citric acid, magnesium oxide and sodium carbonate dissolved in the flushing liquid.

Best, et al<sup>4</sup>, investigated 113 dissolving agents for gall stones and found only ether and chloroform to be satisfactory solvents. He reported 80 per cent success when heated chloroform instilled through the T-tube was used. A biliary flush regime using decholin, olive oil and other instillations was given at the same time. A specially designed T-tube was used by Baker<sup>2</sup>.

#### COMMENT

Successful dissolution or expulsion of retained common duct stones would be a welcome procedure to surgeons who are faced with the serious problem of reexploring the common duct. Pribam reported 51 such cases without a failure. However, recent investigations reported in the literature indicate that the nonoperative procedure is neither uniformly effective nor entirely safe. In the case reported here, after careful and persistent attempts to dissolve and expel the retained stones, surgery was required to effect their removal. Elevated serum alkaline phosphatase in the absence of biliary obstruction followed the ether instillations and persisted for five months.

Opinions differ as to the mechanism of action on the stones resulting from the flushings. Some investigators believe that the non-calcium stones are dissolved, while others believe fragmentation of the stones occur and that the fragments are expelled by relaxation of the sphincter and increased pressure produced by the vaporized ether. The non-calcium cholesterol stones removed from the case reported here failed to dissolve in the ether and alcohol in vitro even after six months. From the literature, a case was reported in which the stones were found subsequently in the stools<sup>3</sup>. In one case, recur-

rent colic occurred two years after apparent successful dissolution of the stones<sup>10</sup>. Considering these instances, the effectiveness and action of the nonoperative procedure has not been established.

The safety of the ether flushing may also be questioned. In our case the elevated serum alkaline phosphatase persisted for five months but no other evidence of liver injury could be detected. Animal investigation has been reported showing greatly reduced bile output<sup>12</sup> during the irrigations and liver biopsy revealed definite injury to the liver cells<sup>13</sup>. Another investigator<sup>4</sup> reported central lobular necrosis of liver cells. The severe pain<sup>12</sup> and shock<sup>6</sup>, that has been reported, is explained by excessive pressure in the biliary system. Recurrent cholecystitis<sup>7</sup> has followed the ether flushings. It seems that the nonoperative procedure is not completely safe despite every precaution to avoid the dangers that have been reported.

### CONCLUSIONS

Persistent and cautious adherence to the details of the non-operative method for removing retained common duct stones failed to dissolve or expel the stones in the case reported here.

Definite evidence of liver injury followed the ether-alcohol flushing regime and the elevated serum alkaline phosphatase did not return to normal for five months.

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### COUGH SYNCOPE

Cough syncope, not widely known to the American physician, has been observed in 25 instances recently. Characterized by sudden syncope following vigorous, unproductive cough, it occurs in middle-aged men who are robust and extroverted, and who indulge heavily in smoking, drinking, and eating. Chronic pulmonary disease — emphysema and bronchial asthma —

often are present. The course of the disease is variable, paralleling the underlying respiratory disease. Although it usually is benign, fatalities have occurred in one to two per cent. The mechanism of the syncope is unproved. Treatment for the most part is symptomatic. *Andrew J. Kerr Jr., M.D. and Vincent J. Derbes, M.D. The Syndrome of Cough Syncope. Ann. Int. Med., Dec. 1953.*

## EDITORIALS



### WHO SHALL BE THE JUDGE?

During the past few years, many free lance science writers have been forced to reach into the bottom of the medical barrel of information for interesting material. There have been no major discoveries, and the antibiotics, heart operations, and latest vitamins are old stuff so far as the editors of newspapers and magazines are concerned. To offset the famine many authors have become sensational or critical or they are out to expose or reform current methods. Since condemnation makes better reading than praise of the medical profession, we can expect more of the former. Oddly enough, praise is regarded as advertising, more so by the medical profession than the editors.

In a recent editorial in the *Journal of the Indiana State Medical Association*, author Alfred Q. Maisel and the *Woman's Home Companion* are taken to task for publishing a misguided and slanted article on cancer: "What is pertinent is the fact that no good purpose is served by certain articles in recent magazines which tend to undermine the patient's confidence in his physician's integrity and professional capability. Such an article dealing specifically with cancer diagnosis and treatment appeared in the January, 1954 issue of the *Woman's Home Companion*, entitled 'How You Can Double Your Chances Against Cancer.' The author, Alfred Q. Maisel, citing a number of cases and quoting

both from the medical literature and from several eminent physicians is able to slant information in such a manner that only the better informed would fail to lose confidence in their physician's ability to deal with cancer. Moreover, Mr. Maisel sets up four conditions which an institution must meet before he considers it a fit place for the diagnosis and treatment of cancer. A list of approximately 150 thus-qualified institutions is presented, and the impression is promulgated that by availing oneself of the services of one of these centers, one's chances against cancer are double. It is interesting that in Indiana only the Indianapolis City Hospital and the Indiana University Medical Center make the elite group; it is equally interesting that in Minnesota, only the University of Minnesota Hospital at Minneapolis is listed; a nearby institution of some renown failed to make the list.

"Although an impression of tacit approval of the article by the American College of Surgeons and the American Cancer Society is implied by Mr. Maisel, these organizations gave quick and loud statements of nonresponsibility. Dr. Paul R. Hawley, writing in the *Bulletin of The American College of Surgeons* under the caption 'Not On Our Doorstep,' clearly outlines the steps taken by the College to prevent the publication of the article, but his advice fell on deaf ears.



**Arkell M. Vaughn, M.D.**

**President, Illinois State Medical Society**

**1954-1955**

"Cancer is being discovered and treated today in many communities in Indiana and other states as skillfully and effectively as in those institutions listed by Mr. Maisel. Even if this were not true, it is obvious that all persons in Indiana wanting examination and treatment for cancer could not possibly be handled by the two institutions listed. Such an article serves only to berate confidence in local facilities specifically and to dispel hope of chances against cancer generally.

"Medicine today seems to make red-hot journalistic copy. Because the subject is complex and not well understood by most readers, it is not difficult to slant facts towards the sensational — a technique designed to increase circulation and newstand sales.

"That Editors may at times be misguided by the enthusiasm of free-lance writers is easily appreciated. A deeper sense of public responsibility, however, in matters so fundamental as the giving of medical advice to their readers should lead editors to heed and heed the counsel of those qualified to give such counsel."

In addition to these editorial comments we might add that the *Woman's Home Companion* and Alfred Q. Maisel lost sight of the fact that more individuals are being cured than die of cancer. Readers will learn ultimately that editors and writers, like physicians, must be responsible to gain the respect of the public. Honesty and a sense of responsibility are basic to the journalistic as well as the medical profession.

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## PRESENT COST OF MEDICAL CARE

Today we hear much concerning the high cost of medical care. Someone has said "there is only one fair measurement of price for an individual in an economy; How long does it take him to earn his wife's clothes, a pair of shoes or a loaf of bread?" One may add—how many hours of work does it take to pay for an office or a home call for a member of his family who is ill?

In my home community 40 years ago the average wage earner received from \$1.00 to \$1.50 per day for 10 to 12 hours of work. A very few made as much as \$2.20 per day. The wage spread was from 8 or 9 cents to 20 cents per hour.

An office call then costs about \$1.00 per visit. The wage earner in the lowest bracket worked

about 12 hours to pay for this service. Those in the higher wage bracket worked about 5 hours to pay for the same service. A home call then cost \$1.50, and it meant about 18 hours work for the lower bracket wage earner, and about 8 hours for those in higher bracket to pay for the call.

Today the lowest bracket wage earner makes at least 75 cents per hour and the higher bracket earners from \$2.00 to \$3.00 per hour. An office call now averages from \$2.00 to \$2.50, so the lower bracket wage earner works about 3½ hours to pay for the call, as compared with 12 hours 40 years ago. Those in higher brackets work an hour or an hour and a half to pay for the same service as compared with 5 hours in 1914.

A home visit now for physicians, costs from \$4.00 to \$5.00, and the lower bracket wage earner works from 4 to 5 hours to pay for it, as compared with 18 hours in 1914. The higher bracket wage earner works two hours to pay for the house visit, as compared with 8 hours in 1914. These comparisons show that the costs for medical care today in this community in relation to wage hours, cost from one fourth to one third as much as the care given 40 years ago.

Then when we consider the type of care the patients receive today with that of 40 years ago, it is quite similar to a comparison of automobiles today and those of 1914.

Bringing this comparison of costs into the hospital field, we note that 40 years ago a hospital day cost from \$2.00 to \$5.00, while today, it averages somewhere between \$8.00 and \$15.00 per day. Workers then had to work from 24 to 60 hours in the lower wage bracket, and from 12 to 24 hours for the higher bracket. Today the low bracket man pays his hospital day with from 8 to 12 hours, and those in the higher bracket, about 8 hours for the room.

Medical care in money, costs more than it did 40 years ago, yet wages have increased much more during this period than have the costs of home visits, office visits, and the hospital costs. The same is true with the many types of medical services rendered to patients in the office, home or in the hospital. The physician must pay many times more for the drugs, bandages and other material he uses in his work, and likewise we all

pay more for automobiles, gasoline, food and clothing than ever before.

So this comparison should prove to the most skeptical layman that he is much better off today in receiving medical care, and in its cost as compared with the average individual's own income than was the worker of 40 years ago.

Tom Kirkwood, M.D.  
Lawrenceville

## **WE ARE SORRY TO SEE YOU GO, GEORGE**

George A. Hellmuth, M.D., of Palos Park, has been appointed Associate Clinical Professor of Medicine and Chief of the Cardiovascular Section in the Department of Medicine of Marquette University School of Medicine, Milwaukee. Dr. Hellmuth has practiced medicine in Chicago for 18 years, and has occupied the position of Assistant Professor of Medicine at the Stritch College of Medicine of Loyola University. We are informed that Dr. Hellmuth will assume these new responsibilities in Milwaukee September 1, 1954, and that he will also head the heart service at the Milwaukee County General Hospital and the Milwaukee Dispensary.

He has been on the staff of the Veterans' Hospital at Hines, The Little Company of Mary at Evergreen Park, St. Francis Hospital in Blue Island and Mercy Hospital in Chicago. He is on the research staff at Hektoen Institute in Chicago. Dr. Hellmuth has been a member of the Council of the Illinois State Medical Society, and for three years has been Chairman of the State Society's Committee on Postgraduate Education. In this capacity he has endeavored to bring to the physicians in all parts of Illinois, good postgraduate programs to their liking. During the last fiscal year, more major conferences have been held than ever before in recent years, with very high interest and good attendance.

Dr. Hellmuth has introduced in Illinois a new type of post graduate service, commonly referred to as the "circuit rider" conference. A physician, carefully selected, is sent to some rural hospital where he goes over some selected cases and discusses them before the physicians present. This has been tried in recent weeks and has been quite successful, and it seems quite probable that more of these one-man conferences will be scheduled during the next fiscal year.

The officers, councilors and many members of the Illinois State Medical Society who have known Dr. Hellmuth and have witnessed his achievements as a teacher, and in his postgraduate endeavors, wish him much success in his new location and contacts. We are all sorry to see him leave Illinois and we desire to inform Milwaukee and the Wisconsin State Medical Society that they are most fortunate in having Dr. Hellmuth added to their membership.

## **DON'T FORGET**

A set of "Medical Ethics," by Dr. Frank E. Wallace, of Monmouth, was taken from a paper read before the Illinois State Medical Society 50 years ago, and published in the July, 1904, number of the Illinois Medical Journal:

1. Don't forget that the public is ignorant, and needs enlightenment.
2. Don't forget that others will criticize—we should praise.
3. Don't express an opinion if it cannot be a good one.
4. Don't forget that prevention is paramount to cure.
5. Don't forget the beam in your own eye when talking.
6. Don't forget to look around for a good example and follow it.
7. Don't forget that in praising others we help ourselves.
8. Don't forget that in performing acts of charity, benevolence and justice, we are character building.
9. Don't forget the Golden Rule.
10. There's no end of fun minding your own business—the other physicians will like you better. No one gets stuck on a knocker—don't be one."

Fifty year old advice demonstrates again that time changes—not people.

## **A LESSON IN JOURNALISM**

A current editorial in the New York State Journal of Medicine, brought forth the following comment on "How Obfuscated Can You Become?": "We are indebted to a correspondent who has submitted to us without comment the following excerpt from 'Winning Chess' by Irving Chernev:

"Not so long ago, a New York plumber observed that hydrochloric acid was highly effective

for opening clogged drain pipes. He enthusiastically passed on his discovery to the U.S. Bureau of Standards, which informed him accurately but stiffly that "The efficiency of hydrochloric acid is indisputable, but the corrosive residue is incompatible with metallic permanence." When it developed that the plumber took this rebuff for high praise, a second warning was sent to him. "We cannot assume responsibility for the production of toxic and noxious residue with hydrochloric acid, and suggest you use an alternative procedure." The plumber remained obtuse and again thanked the Bureau. At this stage another scientist was called in. His message—"Don't use hydrochloric acid. It eats hell out of the pipes." This message was understood."

"We do not play chess ourself, but it is quite possible our correspondent is unaware of this fact. Even if we did, there seems to be little relevancy in this intricate narrative of the plumber's correspondence with the Bureau of Standards and the moving of little men from one square to another. As a mere scrivener, knowing even less about the intricacies of the plumbing trade than about chess, we are at a loss to understand our correspondent's motivation in submitting the excerpt to us. Why did he take the trouble?"

"We publish this in the forlorn hope that perhaps some of our readers or authors may be able to supply the answer. If not, at least they may acquire an insight into some of the perplexities that beset an editor."

## **SECOND ANNUAL "MARCH OF MEDICINE" TELECAST**

On the second anniversary of the first "March of Medicine" telecast, TV cameras will again go to the scene of the nation's largest medical meeting, the Annual Meeting of the American Medical Association.

From the West Coast, Smith, Kline & French Laboratories and the AMA will telecast a March of Medicine report to the nation on the 103rd Annual Meeting, in Civic Auditorium, San Francisco, Thursday night, June 24. Once again, the facilities of the National Broadcasting Company's television network, covering 76 stations for this program, will carry on-the-scene views of the nation's physicians studying medical advances.

An audience of almost 14,000,000 viewers—as with the previous programs in the Fall and Spring series of the March of Medicine—is expected to be watching at 10 p.m. Eastern Daylight Saving Time.

The June telecast comes just two years after the first March of Medicine program from the convention floor of the Chicago meeting of the A.M.A. The Clinical Session in Denver and last June's Annual Session in New York were televised on the March of Medicine, followed by a special series starting last October, which so far has covered heart disease, cancer, the St. Louis AMA meeting, overweight, and arthritis and rheumatism. The telecasts have achieved some of the highest TV ratings obtained by documentary-type programs.

# MEDICAL ECONOMICS

**The Medical Economics Committee. John R. Wolff, Chairman, Walter C. Bornemeier, Edward W. Cannady, Roland R. Cross, Jr., E. F. Dietrich, W. W. Fullerton, Edwin F. Hirsch, Frederic T. Jung, W. R. Malony, Caesar Portes, William Requarth, Frederick W. Slobe.**



## Illinois Medical Service (Blue Shield) Increases Benefits\*

**Frederick W. Slobe, M.D., Chicago**

**Medical Director, Illinois Medical Service (Blue Shield)**

The Blue Shield Plan of Illinois Medical Service, in accordance with established policy, will soon increase benefits in its General Certificate again with no increase in membership dues. The effective date of this change is expected to be about September 1, 1954 and the exact date will be indicated by appropriate announcements. This policy, consistently followed by Illinois Medical Service, should be particularly gratifying when viewed in the light of price and cost increases which have prevailed in most segments of our economy during the recent long inflationary period. And this is the second time that reserves have been built up and the Plan has grown to a point where benefits can be increased.

The progressive increase in the general price level has caused some to inquire why Blue Shield has not followed suit and adopted the same expedient of raising its dues periodically and increasing benefits correspondingly. Although this is a logical and natural question, it does not

take into consideration the number of people who might be unwilling to pay the increased dues because there is always the problem of striking the correct balance between benefits paid and the dues charged. That Blue Shield has found a reasonable balance seems to be indicated by public acceptance, and its growth to almost a million members in 6 years.

This should not be interpreted to indicate, however, that Blue Shield is opposed to a general increase in benefits, since increased benefits and liberalization have been the pattern followed ever since its inception. Furthermore, constant consideration is being given to the possibility of a future offering of certificates carrying benefit schedules up to 50 per cent or more higher than the present schedule, with a corresponding increase in the dues charged the members. This would be available to groups desiring such increased coverage.

Another consideration, strange as it may seem to some, is that when allowances are steadily increased, some of them may actually exceed the customary charges in a given community.

\*This article refers only to the Blue Shield Plan of Illinois Medical Service with headquarters in Chicago. It should not be confused with other Blue Shield Plans in Illinois and adjacent states.

This is because of the variance in charges not only in different communities but, also, by different physicians in the same community. It is also worthy of note that the closer Blue Shield allowances approach average charges, the more likely they are to be considered by the public as an indication of what the doctor should charge. Such an inference is in direct contradiction to the expressed policy of this Plan which always has been that the allowances neither fix nor have any relationship to a physician's charges. The physician remains the sole judge as to the amount of his fee, deciding when the Blue Shield allowance should be accepted as payment in full for those in the lower income group, and how much he should charge in addition, for the others.

Any publicized schedule of medical allowances or fees is abhorrent to many physicians because of the frequent tendency of the public to consider such listed amounts as average charges. However, these lists and schedules, applicable to a large percentage of the 90 million people in this country covered by some form of health insurance, are essential for the successful operation of the plans. So isn't the nuisance of publicized schedules, forms to fill out and a certain amount of red tape, a small price to pay for the satisfaction of participation in a movement which has such wide public acceptance and is such a powerful bulwark against the threat of socialized medicine?

So, perhaps the answer lies in adequate information to your patients concerning Blue Shield. Whenever schedules are published it should be explained that they do not relate to physicians' charges. Blue Shield, too, should use every opportunity to emphasize this to its members. And the physician, likewise, can avoid misunderstanding by explaining it to his patients.

#### MEDICAL CARE

The following are the new allowances which apply toward professional medical (nonsurgical) care of members hospitalized for three or more consecutive days, limited to one visit per day:

\$5.00 for each of the first 5 hospital visits

\$3.00 for each of the next 65 hospital visits

Maximum benefit 70 hospital visits (may be repeated as described below)

If a Member enters any hospital within 90

days of discharge from any hospital, medical benefits paid for previous visits are cumulative and the total is used in determining available benefits, subject to the 70 visit maximum, the two day waiting period, and payment of \$3.00 per visit. When such a 90 day interval does occur, all of the medical care benefits are again available under the same conditions; that is, \$5.00 for the first 5 visits and \$3.00 for the next 65 visits, irrespective of whether the 65 occupy one or multiple hospitalizations.

Example of payments covering more than one hospitalization:

June 1 to July 15;

\$5.00 for the first 5 visits — \$ 25.00

\$3.00 for balance of 40 visits — 120.00

Total for first admission — \$145.00

Second admission August 1 to August 31  
(25 visits still available)

\$3.00 for 25 visits — \$75.00 available,  
making a maximum total of \$220.00 for  
the 2 admissions.

Medical benefits would become available again on December 1, namely, 90 days from date of discharge from the hospital.

Additional allowances for shock therapy and skin tests for hospital inpatients remain the same except that they are not subject to inclusion in computing any total yearly maximum as heretofore.

The increased benefits in the medical schedule, then, may be summarized as follows:

- A. Increased allowances for short stays; for example, the former allowance for a 4 day stay was \$10.00, whereas it is now \$20.00. The former allowance for a 10 day stay was \$25.00, whereas it is now \$40.00.
- B. Reduction in waiting period from 3 days to 2 days. Formerly, there was no payment for a three day stay, whereas now payment is \$15.00. There is no payment, however, for stays of 1 or 2 days.
- C. Cancellation of waiting period with payments retroactive to the first day for stays which exceed 2 days. Formerly, there was no cancellation of the waiting period.
- D. Elimination of a maximum based on a calendar year, with the substitution of an increase in potential medical benefits available during a comparable period. Formerly, there was a \$180.00 maximum per calendar

year. This calendar year basis has been eliminated and a 70 visit allowance per admission or series of admissions substituted. These allowances are cumulative up to 70 visits for multiple admissions unless separated by a 90 day period between date of discharge and admission. After the lapse of such an interval, a new cumulative 70 visit total again becomes available. This would increase the theoretical possible medical payments during a year to about \$650.00, including the available allowances for shock therapy.

Much consideration was given to the feasibility of establishing a schedule of special allowances to apply toward the care of a specified list of certain serious medical conditions. No unanimity of opinion could be reached, however, after consultation with committees and individual physicians representing the internists and general practitioners. The problem, therefore, remains under advisement.

#### SURGICAL CARE

##### *Office surgery*

Benefits now apply for the following procedures performed in the physician's office or clinic, and in the patient's home:

- Tonsillectomy and adenoidectomy
- Submucous resection
- Excision of nasal or aural polyps
- Excision of chalazion
- Low ligation of varicose veins
- Excision of anal fissure
- Rectal polypectomy
- Excision of cervical polyps
- Conization of cervix
- Initial endoscopy (including only cystoscopy, bronchoscopy, esophagoscopy, gastroscopy, and direct laryngoscopy)
- Circumcision
- Suturing of wounds
- Removal of foreign bodies by incision
- Excision of tumors and cysts
- Incision of abscess
- Abdominal paracentesis
- Fractures and complete dislocations

Although formerly eligible for benefits when performed in a hospital outpatient department, these procedures were not covered when performed in a physician's office, with the exception of fractures and dislocations which have always been covered, wherever treated. Additions to the

list include excision of chalazion, abdominal paracentesis, and removal of foreign bodies by incision. This list includes most of the common operations performed in a doctor's office or the outpatient department of a hospital.

##### *Increased allowances for certain surgical procedures*

Allowances for some surgical procedures have been increased, examples being the following:

	increased from	
Spinal fusion,	\$125.00 to	\$150.00
Open reduction of		
fractured humerus	125.00 to	150.00
Tracheotomy	50.00 to	75.00
Porto-caval anastomosis	175.00 to	200.00
Excision of submaxillary		
gland	50.00 to	75.00
Femoral hernia	75.00 to	100.00
Drainage of kidney abscess	100.00 to	125.00
Ureterotomy	100.00 to	125.00
Colpoplasty; repair of		
cystocele	50.00 to	75.00
Craniotomy, suboccipital	150.00 to	200.00
Excision of intervertebral		
disk	125.00 to	150.00
Repair of encephalocele	100.00 to	125.00
Sympathectomy,		
cervicothoracic	125.00 to	150.00
Extraction of lens	100.00 to	125.00

##### *Multiple unrelated operations*

The full scheduled allowance will be paid for each of two or more operations performed during the same hospitalization provided they are wholly unrelated and performed in different areas. This, of course, will be subject to the previous total maximum of \$200.00 available during a 90 day period.

##### *Emergency accident care in a hospital*

An allowance of \$5.00 is made for emergency accident care in a hospital, if given within 24 hours after an accident, to apply to instances where no other scheduled allowance is available. There was no previous coverage for this type of service.

#### ANESTHESIA

Many increases in individual anesthesia allowances have been made, including an increase in the maximum from \$25.00 to \$35.00. A partial list of the increases is as follows:

Anesthesia for cholecystectomy increased from \$15.00 to \$20.00  
for congenital heart operation from \$25.00 to \$35.00  
for gastrectomy from \$20.00 to \$30.00  
for hysterectomy from \$15.00 to \$20.00  
for obstetrical delivery from \$10.00 to \$15.00  
for thyroidectomy from \$15.00 to \$20.00

#### RADIOLOGY AND PATHOLOGY

Although the allowances remain the same, the \$15.00 limitation per calendar year for diagnostic x-ray service and pathology service has been abolished and liberalized to a \$15.00 maximum total allowance within a 90 day period. When such a period does elapse, new benefits again become available beginning with the date of service.

The allowances for radiation therapy for proved malignancy remain the same.

#### SUMMARY

All of the foregoing liberalizations of Blue Shield coverage have been effected without any

increase in membership dues. A Certificate is being planned carrying a higher schedule of allowances for groups desiring it. Intervention by a third party is minimized beyond what is essential in administering the Plan. Payments are made to physicians; free choice of physician and hospital, and the physician-patient relationship are maintained. By law, physicians must always constitute the majority on the Board of Trustees. The physician establishes his fee as usual, the Blue Shield allowance being credited toward it.

The rapid growth of the voluntary Plans and the progressive broadening of their coverage indicate that they are solving a major portion of the problem involved in the financing of hospital and medical care. Under local auspices and control, they are rendering more and more ineffectual, the threat of government compulsory health insurance and socialized medicine.

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## DEAFNESS IN CHILDREN

Detecting hearing loss in a 2 or 3 year old child often is a difficult matter. Clapping hands behind the child's back or stamping or banging a door and watching his reaction is no proof that he can or cannot hear. Frequently he may feel the vibrations and respond without actually hearing. On occasion the child may hear quite well and not give any definite response to sound stimuli despite intensive urging and ingenious efforts by the examiner. It requires patience, skill, and much experience to evaluate hearing impairment in young children. Often this should be done by a well-equipped specialist who has the time and is willing to make the effort to investigate the problem. Unfortunately, there is as yet no simple, reliable method of ob-

jectively measuring hearing acuity. Consequently, a number of young children with severe hearing losses often are misdiagnosed as aphasic, feeble-minded, dull, psychotic, or "he will grow out of it." Inaccurate and inconclusive diagnoses frequently result in improper medical and educational measures. In our experience the psychogalvanic skin resistance test has proved to be one of the most effective means of obtaining an accurate hearing evaluation on a child below the age of 5. This is an objective test of hearing requiring no subjective response from the patient and is particularly applicable to young children. It should be used along with speech reception testing and a complete medical examination. *Joseph Sataloff, M.D., and George M. Coates, M.D., Editorial, The Hard of Hearing Child. Pennsylvania M. J. Dec. 1953.*

## THE P.R. PAGE



### ADAMS ACTIVITY

The Adams County Medical Society has an extensive and energetic public relations program, its secretary, Newton DuPuy, M.D., of Quincy, reports. It is headed by Harold Swanberg, M.D., public relations chairman. Dr. DuPuy writes:

"The Adams County Medical Society sponsors a Physicians Exchange which is advertised to the public like this: If you do not have a physician or are unable to locate your physician, call the Physicians Erchange.

"A Medical Secretaries' and Assistants' Club has been organized three years and is meeting regularly each month. There are about sixty members.

"We have one member of the Public Relations Committee who handles newspaper releases and acts as liaison.

"We also sponsor TV and radio programs weekly over two stations. We are using the A.M.A. films.

"Each year our Public Relations Committee puts on a program. This year the program was held May 10 and W. W. Bauer, M.D., director of the A.M.A. bureau of health education spoke on 'Patients Are Particular People.'

"The Adams County Medical Society also sponsors a hearing conservation program.

"Let me also remind you of the Century of Health Pageant which was put on in 1950 to

commemorate our 100th year, at which time we had a huge exhibit tent and did free chest x-rays, eye examinations, blood pressure determinations, hearing tests, etc.

"We have planned to have health forums each of the past two years, but this has not come about as yet."

Members of the committee, in addition to Dr. Swanberg and Dr. DuPuy, are Milton E. Bitter, M.D., Carl F. H. Pfeiffer, M.D., and Hilliard M. Shair, M.D. For the public relations meeting mentioned, the society also invited dentists, pharmacists, nurses, public health personnel, and medical and dental secretaries and other aides.

### THE P.R. DINNER

With a June Journal deadline of May 11, it is of course impossible to report on the P.R. dinner during the annual meeting. The report will be carried in the July issue. Meanwhile, the Committee is glad to record that, within 48 hours after the invitations went out, more than 40 reservation cards came back.

### FUGITIVE FROM NEWS

When the first news releases on the annual meeting went out to newspapers and radio stations early in May, one executive bounced it right back to the public relations office. "I cannot see any particular news value other than just plain public relations propaganda and ad-

vertising for the medical profession in general," he wrote.

That is the second such response to an Illinois State Medical Society news release in the more than eight years of its P.R. service. In a release such as this, which described the meeting as drawing leading medical men from all parts of the state, most news editors check local sources for word of who is going to attend from the home town and make a local story of it. Most editors welcome such information opening up local stories. Furthermore, few medical societies have funds to buy radio time or newspaper space, as the writer thinks they should. Even if they did, such expenditures would not be warranted for such a release, which is distributed as a service to news men.

The committee is following through on the letter by way of the county society involved and will report the outcome in a later issue of the Journal.

### PARABLE FOR TODAY

When the meat packer processes a steer, he can choose one of two methods. He can cut it into the tender rib roasts, tenderloins and sirloins, the round steaks, chuck and rump roasts, and the briskets and other odds and ends. He prices them according to their quality and demand and sells to whoever will pay those prices.

The buyer then balances his funds with his desires and selects his cut. If he can, he buys the fine cuts from prime steers; if he cannot, he buys a lesser cut, or a cut from a lower grade steer.

More important, if he can't afford what he wants today, he can determine to increase his earning capacity in some way, so that he can buy what he prefers.

The second course open to the meat packer is to put every animal through the grinder and sell the whole thing as hamburger at one price. The buyer takes it as is; he has no choice. There is no use wanting anything better or trying to earn a better quality. There isn't anything to earn. There is only hamburger. Everyone, regardless of his financial status, is held to the same low level.

The first course represents Capitalism, and the second course represents Socialism.

The one is a system based on personal reward

measured by personal contribution, motivated in turn by personal incentive and the opportunity to earn the good and better things of life. The citizen has a wide choice, dependent only on his individual ambition and ability.

The other is a system based on the Socialist principle "to each according to his need", without incentive or opportunity to earn more. Who needs more than hamburger after all? And, if there is only hamburger, what good is it to want better? And if you don't even know there is anything better, how can you want it? The citizen has his choice of hamburger.

The analogy is not a mere attempt to be amusing. We still have a largely Capitalist civilization — one of the few left in the world. What its attackers would impose on us step by step is the "hamburger" social and economic structure of Socialism. When we oppose the socialization of medicine, we are fighting Socialism.

### WORKMEN'S COMPENSATION

The practical workings of the Workmen's Compensation setup in Illinois have recently come to the fore as a problem for the Committee on Industrial Health and for the Committee on Medical Service and Public Relations. County society officers and P.R. chairmen should be on the alert. The background:

The American Medical Association Council on Industrial Health made a survey of the compensation picture as it involved physicians in various states, including Illinois last summer. The report, as forwarded to this society, did not present a satisfactory picture. Physicians' roles in giving care, fixing fees and offering testimony were shown in an unfavorable light.

The Council directed the Committee on Industrial Health to take the responsibility for a cleanup. Full publicity was authorized, both as an aid in rehabilitating the system, and to show the public the medical profession's determination to keep its own house in order. The society had the report printed in a 61-page brochure. The Committee on Industrial Health has embarked on a series of conferences with interested groups — the Illinois Industrial Commission, employers, labor and the legal profession — to determine the best course to pursue. Legislation may be required.

The problem, however, is statewide and may

arise in any county. Officers should be alert therefore, to protect the name of the medical profession by explaining our role, and even by ethical relations committee action, and to support whatever legislative action may be asked.

#### **PLACEMENT SERVICE**

The detailed report on the physicians' placement service operated from the Secretary's office,

which appeared in the J.A.M.A. of October 17, 1953, is available in reprints. It describes procedures by which areas needing physicians and physicians seeking locations are brought together. This, too, is a problem that may crop up in any component society's jurisdiction, so that every county secretary should be familiar with the system.

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#### **THE CONVENTIONAL METASTATIC**

Physicians should abandon the thought that certain cancers are not expected to spread to the lungs or to the bones, and replace it with a program of radiographic surveying of the lungs and major red bone marrow areas for cancers with a high metastatic index, such as those of the breast, prostate, kidney, lung, thyroid gland, bones, or testicles. In addition, there should be a policy of x-ray investigation of atypical symptoms referable to lungs, skeleton, central nervous system, or intestinal or urinary tracts in the clinical follow-up study of all patients with neoplastic disease. In my experience, relatively early widespread metastatic disease from cancer of the lung, stomach, and pancreas coincides with disappointing results from radical surgery of these lesions. Still earlier diagnosis of these primary cancers remains essential. On the other hand, a tendency for cancers of the larynx, colon, rectum, uterine fundus, and to a lesser degree, uterine cervix, to remain anatomically resectable longer coincides with relatively good percentages of five year survivals in these conditions. One gains the impression, from a combination of autopsy and clinical follow-up study, that cancer of the oral cavity offers a good field for radical surgery as well as radical radiation and that the regional lymph nodes provide a helpful barrier in the delay of neoplastic extension distally. *John W. Turner, M. D., OBSERVATIONS ON NEOPLASTIC SPREAD. New England J. Med. Sept. 24, 1953.*

#### **VAGOTOMY**

I think the recent work on section of the vagus fibers for treatment (of peptic ulcer) indicates somewhat the association between worry and gastric function. Also, the whole concept of the adaptation syndrome emphasizes the constant association during stress of the formation of erosion, stasis, hyperemia, derangement in tissue nutrition, breakdown of cells, and exposure to highly destructive gastric juice. With the alarm reaction, there is acute gastric and duodenal hyperemia and erosion, sometimes with hemorrhage into the stomach, as a constant and characteristic manifestation of the first stage in the general adaptation syndrome. These factors merely indicate that the etiology, at least, may be associated with stress, although this is not always so. *H. Marvin Pollard, M.D., Evaluation of Present Day Treatment of Peptic Ulcer. Postgrad. Med., Dec. 1953.*

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The patients considered not suitable for home care are those with progressive disease requiring constant medical or nursing care and those with open cavities and persistent tubercle bacilli in the sputum. Those patients need active measures such as surgical therapy or involved diagnostic procedures, and are best kept in the hospital. Furthermore, home care is not used for custodial types of patients with chronic fibrotic tuberculosis. Editorial, GP, Jan., 1954.

## CORRESPONDENCE



### CLINICS FOR CRIPPLED CHILDREN LISTED FOR JULY

Twenty-four clinics for Illinois' physically handicapped children have been scheduled for July by the University of Illinois Division of Services for Crippled Children. The Division will count 19 general clinics providing diagnostic orthopedic, pediatric, speech and hearing examinations along with medical social and nursing services. There will be 4 special clinics for children with rheumatic fever and 1 for cerebral palsied children.

Clinics are held by the Division in cooperation with local medical and health organizations, both public and private. Clinicians are selected among private physicians who are certified Board members. Any private physician may refer to or bring to a convenient clinic any child or children for whom he may want examination or may want to receive consultative services.

The July clinics are:

- July 1 — Cairo, Public Health Building
- July 7 — Carrollton, Carrollton Grade School
- July 7 — Hinsdale, Hinsdale Sanitarium
- July 8 — Elmhurst (Rheumatic Fever), Memorial Hospital of DuPage County
- July 8 — Springfield, St. John's Hospital

- July 8 — Sterling, Field House
- July 9 — Chicago Heights (Rheumatic Fever), St. James Hospital
- July 13 — East St. Louis, St. Mary's Hospital
- July 13 — Flora, Clay County Memorial Hospital
- July 13 — Peoria, St. Francis Children's Hospital
- July 14 — Joliet, Will County T.B. Sanitarium
- July 16 — Evanston, St. Francis Hospital
- July 20 — Danville, Lake View Hospital
- July 20 — Quincy, St. Mary's Hospital
- July 21 — Evergreen Park, Little Company of Mary Hospital
- July 22 — Bloomington, St. Joseph's Hospital
- July 22 — Mt. Vernon, Masonic Temple
- July 22 — Rockford, St. Anthony's Hospital
- July 23 — Chicago Heights (Rheumatic Fever), St. James Hospital
- July 27 — Effingham (Rheumatic Fever), St. Anthony's Memorial Hospital
- July 27 — Peoria, St. Francis Children's Hospital
- July 28 — Alton, Alton Memorial Hospital
- July 28 — Aurora, Copley Memorial Hospital
- July 28 — Springfield (Cerebral Palsy), Memorial Hospital

## TO THOSE INTERESTED IN CYTOLOGY

The second annual meeting of the Inter-Society Cytology Council will be held in Boston, Friday and Saturday, November 12 and 13, 1954. Those having material to present are invited to submit three copies of the title and an informative abstract of not more than 200 words to Dr. John B. Graham, Chairman of the Program Committee, 32 Fruit Street, Boston, Massachusetts, before July 15, 1954. Abstracts of all papers accepted will be published in the official program.

Papers will be limited to fifteen minutes. They will be discussed in related groups rather than individually. A maximum of eight papers will be presented to each session.

The diagnostic accuracy in cancer of the cervix and the lung is so well established that further verification at this meeting is not indicated.

Particular attention is suggested for the endometrium and lesions of the gastro-intestinal and urinary tract.

Papers read by title and abstracted in the program may be discussed if time permits.

The authors of papers, selected for presentation, will be notified by September 30, 1954.

The Scientific Program will comprise four consecutive sessions.

Section 1. Special Techniques, including Cytochemistry, Ultraviolet and Electron Microscopy —

Chairman, Dr. James W. Reagan

The second half of the Section will be devoted to General Cytology.

Section 2. Prognosis in the Treatment of Cancer by Cytologic and Histologic Techniques —

Chairman, Dr. Arthur T. Hertig

Section 3. New Developments in Cytology —

Chairman, Dr. Emerson Day

Section 4. Round Table Discussion of the Carcinoma In-Situ Lesion —

Chairman, Dr. John R. McDonald

Place of Meeting — Statler Hotel, Boston, Massachusetts. You are urged to make your reservations directly with the Reservations Manager, Statler Hotel, Boston, Massachusetts.

Registration will be open to everyone interested in Cytology. Registration fee for physicians is \$5.00; for cytologic-technologists, tech-

nicians and others, \$2.00. Medical students, internes and residents will be admitted without charge.

For additional information please contact the Secretary-Treasurer, Inter-Society Cytology Council, 634 North Grand Blvd., St. Louis, Missouri.

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## THE AMERICAN CONGRESS OF PHYSICAL MEDICINE AND REHABILITATION

The 32nd annual scientific and clinical session of the American Congress of Physical Medicine and Rehabilitation will be held September 6-11, 1954 inclusive, at the Hotel Statler, Washington, D. C.

Scientific and clinical sessions will be given September 7, 8, 9, 10 and 11. All sessions will be open to members of the medical profession in good standing with the American Medical Association.

In addition to the scientific sessions, annual instruction seminars will be held. These lectures will be open to physicians as well as to therapists, who are registered with the American Registry of Physical Therapists or the American Occupational Therapy Association.

Full information may be obtained by writing to the executive offices, American Congress of Physical Medicine and Rehabilitation, 30 North Michigan Avenue, Chicago 2, Illinois.

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## COURSE IN POSTGRADUATE GASTROENTEROLOGY

The National Gastroenterological Association announces that its Sixth Annual Course in Postgraduate Gastroenterology will be given at The Shoreham in Washington, D.C. on 28, 29, 30 October 1954.

The Course will again be under the direction of co-chairmanship of Dr. Owen H. Wangensteen, Professor of Surgery of the University of Minnesota Medical School, who will serve as surgical co-ordinator and Dr. I. Snapper, Director of Medical Education, Beth-el Hospital, Brooklyn, N. Y., who will serve as medical co-ordinator.

Drs. Wangensteen and Snapper will be assisted by a distinguished faculty selected from the medical school and Walter Reed Army Hospital, whose presentations will cover all phases of gastrointestinal diseases and problems.

The entire session on Friday, 30 October 1954 will be given at the Walter Reed Army Hospital.

For further information and enrollment write to the National Gastroenterological Association, Department GSJ, 33 West 60th Street, New York 23, N. Y.

## **DO YOU RECEIVE THE HEART BULLETIN?**

In cooperation with the Cardiovascular Committee of the Illinois State Medical Society, and the Illinois Heart Association, for the past year we have made available to a limited number of physicians in downstate Illinois, complimentary subscriptions for the Heart Bulletin.

Whether the providing of this publication was to continue depended upon the reaction of the physicians on the mailing list. Questionnaires sent these physicians resulted in a 74.8% reply, and of those replying 89% stated that they wished to remain on the complimentary mailing list and that the Heart Bulletin was useful to them in their medical practice.

Based on these encouraging results, we intend to continue the complimentary copies of the Heart Bulletin to the original group of physicians who indicated their interest. In addition, however, we would like to make complimentary subscriptions available to other physicians in downstate Illinois who would also like to be placed on the mailing list.

I would appreciate it, therefore, if in the next issue of the Illinois Medical Journal you would call attention to the fact that any physician who is not now receiving the Heart Bulletin and who wishes to be put on the mailing list, may do so by addressing a communication to me to this effect, giving his full name and address.

This does not apply to physicians in Chicago and Cook County, since they are receiving the Heart Bulletin through the Chicago Health Department, and the Illinois Heart Association.

G. Howard Gowen, M. D.  
Deputy Director

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## **SURGERY IN THE AGED**

It is obvious that the problem of surgery in the aged has become one of major importance because of the sheer number of persons involved. The philosophy expressed in a phrase still frequently heard — “Why not let the poor old man die in peace?” — can hardly be regarded as acceptable when there are 8,000,000 to 9,000,000 people past the age of seventy, among whom the incidence of surgical disease is disproportionately high.

It is to be expected that the frailties imposed by advancing years will increase the hazards of surgery in the aged. Pediatric surgeons have repeatedly pointed out that the infant or small

child cannot be regarded as a small-sized adult; so, too, the old patient cannot be regarded simply as a person who has enjoyed a longer span of life. This is not to suggest a need for geriatric surgeons, but the surgeon who accepts responsibility for the management of surgical problems in the aged must, if he wishes to maintain an acceptable mortality and morbidity rate, be thoroughly familiar with the special problems imposed by age and willing to expend the time and effort required to deal with them. *Thomas J. Anglem, M.D., Brookline, Massachusetts, Martin L. Bradford, M.D., Brookline, Massachusetts, Major Surgery in the Aged. New England J.-Med., December 17, 1953.*

# COUNCIL MEETING MINUTES



The regular April meeting of the Council was held at the Hotel Sherman, Chicago, on Sunday, April 25, 1954. The following were present: Lewis, Vaughn, Nicholson, Kirby, Camp, Lundholm, O'Neill, Stone, Hellmuth, Piszczek, Oldfield, Reichert, Hesseltine, Blair, Reisch, Newcomb, Goodyear, English, Montgomery, Fullerton, Hamilton, Sweeney, Hopkins, Coleman, Cross, Limarzi, Hedge, VanDellen, Bornemeier, Fowler, Hoeltgen, Leary and Frances Zimmer. By proper action minutes of previous meeting were approved.

Lewis reported as president, telling of the many activities since the last meeting. March 20-21, meetings in Indianapolis, first day, officers of six adjoining state societies met to consider many mutual problems. Following day, AMA regional meeting to discuss problems relative to care of veterans with non-service connected disabilities in V. A. hospitals. April 1, meeting in Springfield, called by Governor to make plans for Mental Health Week, May 2-9. Attended Secretaries' Conference in Springfield on April 4, which proved to be an interesting affair, and the president recommends that it be scheduled in the interim between annual meetings each year in the central part of Illinois. He spent the following week in Secretary's office at Monmouth, going to Chicago with the Secretary on Wednesday, and also a meeting of the Tazewell County Society during the week. He was on the program for the P. G. Conference in Kewanee, on April 15 and his address was broadcast by a local radio station. He also referred to a number of other county societies visited during the recent weeks.

Vaughn reported as President-Elect, referring to a number of meetings he had recently attended. He attended post-graduate meetings in Waukegan and Springfield on two consecutive days. He referred to the C. M. S. "Governor's Reception" the previous eve-

ning, held at the Hotel LaSalle, and which was attended by the Society officers, and most of the members of the Council. He thought it a well worthwhile project.

Secretary gave supplementary report, his report having been mailed to members prior to the meeting. Told of the brochure recently published at the request of the Committee on Industrial Health, following the survey made by the A. M. A. Council on Industrial Health using Illinois as the state for a pilot study. Many requests have been received for copies of this brochure, which was mailed to each member prior to this meeting. He stated that the annual audit was underway and reports would be available by the time of the Annual Meeting. He noted there had been an increase of some 90 members during the present fiscal year.

Hopkins reported as Chairman of the Committee on Medical Service and Public Relations; Committee has held several meetings interviewing candidates for the position in this Society held by John W. Neal during the past 12 years. The Committee has no recommendation to make to the Council at this time, but will hope to have a recommendation by the time of the Annual Meeting. Leary told of his work as P.R. Director, and of some meetings recently attended.

Secretary stated that an accompanying letter was to be sent out with the brochures published for the Committee on Industrial Medicine; had copy of proposed letter to go out under signatures of the President, Chairman of the Council, and Dr. Hamlin as Chairman of the Society Committee on Industrial Medicine. Motion: Blair-Sweeney, that letter be approved and sent out with the books. Motion carried.

Hopkins referred to the contract with the Veterans Administration, which would expire on June 30. This in reference to the "Home Town Care of Veterans with Service-Connected Disabilities". Hopkins recommended

that it be approved for another year. Motion: Vaughn-Montgomery, that it be approved. Carried.

Hellmuth reported as Chairman of the Post Graduate Education Committee, telling the Council that this would be his last report on P. G. Services, as he was leaving Chicago to take a teaching position at Marquette University, Milwaukee, head of the Department of Cardiology. He reviewed the work of his committee for the three years he has been chairman, and he told of the conferences which have been scheduled during the present fiscal year. More conferences, with a relatively good attendance for practically all of them. He believes these conferences can be increased and improved during coming years, giving some statistical information and suggestions which he believes will improve the subject matter as well as attendance at future conferences. Motion: English-Lewis, that the Council express its gratitude to Dr. Hellmuth for the fine work he has done, his interest in post graduate education, and also for the fine report he has presented. Motion carried by a rising vote.

Montgomery told of the work of the Medical Advisory Committee to the Illinois Public Aid Commission. Told of the long meeting of the previous day which began at 3:00 P. M. and continued until after the dinner hour. Three physicians were called in to explain certain charges or services rendered to clients of the I. P. A. C., then several policies were discussed by the group. Montgomery reported that at this meeting the Committee decided to go into executive session to consider various problems, then report to the representatives of the I. P. A. C., as to the findings and recommendations. This procedure will be followed at future meetings of the committee.

Limarzi reported on the Student A. M. A., as represented in the five Illinois medical schools. In these five schools there are approximately 2095 students, and of this group there are some 1293 members of the Student A. M. A. This shows that slightly more than 60% of these students have affiliated themselves with this relatively new organization. (Limarzi reported as Chairman of the Committee on Arrangements for the 1954 Annual Meeting, showing that plans completely formulated are being carried out properly.

Hesseltine reported as Chairman of the Liaison Committee on Medical Education, telling of the responses to date, on the questionnaire form sent to all component and branch societies on the osteopathic problem. This was a report of progress, and a more detailed report will be given to the House of Delegates during the Annual Meeting. Motion: Hesseltine-English, that Illinois Delegates to the AMA meeting in San Francisco, take with them the implied sense of this Society, and reflect their thinking on the action taken by the House of Delegates. Motion carried.

Dr. Cross reported as Director, State Department of Public Health, telling of some recent problems before the Department. He told of a new activity endeavoring to bring about the best possible programs of health services in the schools of the State. He told of the reactivation of the State Wide Public Health Com-

mittee, first organized in 1942 and which had much to do with the enactment of the county health department law. This has been adopted in 27 counties, and had become dormant on account of the shortage of public health personnel.

Fullerton reported on the activities of the Educational Committee, Sub-Committee on School Health, of which George L. Drennan is chairman. The Committee met recently in Springfield with representatives of the State Health Department, Dentists and teachers, to discuss the advisability of continuing the conferences such as was held last year at the University of Illinois. It was decided that these conferences during the next year should hold two or three area meetings in different parts of the state. It is desirable to maintain and improve our relations with the school people and children.

Some discussion relative to the presentation to the outstanding general practitioner of Illinois to be honored during the Annual Meeting. It was considered advisable for the Society beginning this year to assume the hotel expenses of the man to receive this honor. By proper action this arrangement was adopted.

Several councilors reported actions taken in their districts, and also told of the several presentations made of Fifty Year Certificates and emblems. Several of these occurred at special meetings with many residents of the community present.

Hoeltgen reported first on the successful Secretaries Conference held in Springfield on Sunday, April 4. He told of similar meetings in neighboring states, and believed it would be well for this Society to send officers of the Secretaries' Conference to adjoining states to attend their similar conferences, as a matter of good will, and also for its educational advantages. Motion: Reisch-Fullerton, that this be done. Motion carried. Hoeltgen then gave a progress report as Chairman of the Society's Committee on Nursing. He discussed one Illinois Hospital which was threatened with a loss of its training school on account of certain demands made by the accreditation group which the hospital is unable to meet.

Motion: Hamilton-Fullerton, that the Council approve the suggestion that the Secretaries or "Component Society Officers Conference" be held in the interim between annual meetings each year. Motion carried.

Motion: Lewis-Vaughn, that Secretary be instructed to renew the subscriptions to the Marjorie Shearon Service for another year. Motion carried.

The report of Dr. G. C. Otrich, who attended the Conference recently at Dallas, Texas, was mimeographed and sent to members prior to the meeting. Motion: Hamilton-Montgomery, that the report of Otrich be approved. Motion carried.

The Council decided to hold meetings on the first three days of the Annual Meeting at breakfast meetings. The fourth meeting to be a luncheon affair, immediately after the end of the last meeting of the House of Delegates on Friday, May 21. By proper action the bills as audited by Finance Committee were approved. The Council adjourned at 12:15 P. M.

Harold M. Camp, M. D., Secretary

# NEWS OF THE STATE



## ADAMS

**Dr. W. W. Bauer Addresses Public Relations Meeting.**—Over 200 physicians, pharmacists, nurses, medical secretaries and technicians, and public health workers heard Dr. W. W. Bauer of Chicago talk Monday, May 10, at the Annual Public Relations Meeting of the Adams County Medical Society, held at the Lincoln Douglas Hotel, Quincy.

Dr. Bauer's talk, entitled "Patients are Particular People", afforded the opportunity to relate some of the voluminous correspondence that flows through his office, in connection with his work as Editor of "Today's Health" magazine and Director of Health Education of the American Medical Association. Dr. Bauer's principal theme was a plea for physicians and all medical personnel to return to the "country doctor" type of relationship with patients, in this day of laboratory reports and scientific emphasis.

Dr. Bauer praised the radio and television programs sponsored by the Adams County Medical Society in cooperation with the Adams County Health Departments.

An informal reception for Dr. Bauer preceded the meeting, and following the talk, all enjoyed the hospitality of the Adams County Medical Society at a snack bar lunch. Dr. Carl Pfeiffer, President of the Society, presided. Dr. Harold Swanberg, Secretary of the Society's Public Relations Committee, introduced Dr. Bauer; and Dr. M. E. Bitter, Chairman of the Public Relations Committee, briefly discussed Dr. Bauer's presentation.

## COOK

**Name Building in Honor of Physician and Wife.**

—A bronze plaque was unveiled, May 10, in the original building of LaRabida Sanitarium in honor of

the late Dr. Robert A. Black and his widow. The ceremony marked the renaming the structure as the Dr. Robert A. Black and Mary Cleland Black Building. According to the Chicago Tribune, the original building was the culmination of Dr. Black's dreams of a place to care for children convalescing from rheumatic fever and heart disease. Mrs. Black, who came to Chicago from Maitland, Fla., to be present at the ceremonies, organized the sanatorium's women's board and handled its business affairs.

**Egon Fischmann Honored on Birthday.**—The seventieth birthday of Egon W. Fischmann, M.D., was observed with a banquet at the Sheraton Hotel, March 20. Five hundred persons, attended including members of the staff of Grant and Cook County hospitals, the faculty of the Chicago Medical School and patients. Announcement was made of a new annual lectureship created by friends and associates, to be known as the Dr. E. W. Fischmann Lectureship in Gynecology. Another honor was set up by one group of associates at Grant Hospital to be known as the Dr. E. W. Fischmann Prize. It will be awarded each year to the best resident in gynecology and obstetrics. Another group at Grant presented air conditioning equipment to the newborn nursery in Dr. Fischmann's honor. Professor and head of the department of obstetrics and gynecology at the Chicago Medical School, Dr. Fischmann is also attending gynecologist at Cook County and Grant hospitals and professor of gynecology at the Cook County Postgraduate School.

**Personal.**—William Bloom, M.D., and Frank H. Westheimer, Ph.D., have been elected to the National Academy of Science, the highest honor in the United States' scientific field. Both are members

of the University of Chicago, Dr. Bloom holding the rank of professor of anatomy and Dr. Westheimer, the rank of professor of chemistry.

#### **DU PAGE**

**Emil Oelke Honored.**—Emil H. Oelke, M.D., Wheaton, was inducted into the Fifty Year Club of the Illinois County Medical Society at a meeting of the DuPage County Medical Society, April 21. Edwin S. Hamilton, Councilor for the Eleventh District, made the presentation of the gold pin and certificate emblematic of the Fifty Year honor.

#### **KNOX**

**Society News.**—The Knox County Medical Society met last evening at the Galesburg Club. The doctors were reminded to encourage their patients to send in questions to the free medical forum being sponsored by the Knox County Medical Society and the Register-Mail. The first of these forums will be held Monday evening, April 19, at 8 o'clock in the Galesburg High School Auditorium. The subject will be "Heart Disease."

The meeting was addressed by Dr. Matthew J. Brunner, Assistant Professor of Dermatology at Northwestern University Medical School. The subject of Dr. Brunner's remarks was "Simplified Rational Treatment of Common Skin Diseases". Slides were used to illustrate his talk.

Dr. Richard Graff, who has been serving for over a year as Secretary-Treasurer of the medical society, is being transferred to Manteno and Dr. Martin List was elected to serve in his place for the remainder of the present year. A vote of thanks was given Dr. Graff for his splendid work.

It was announced that a radio program "Your Doctor Speaks" consisting of 13 radio programs on medical and health education of interest to the general public will be sponsored by the Knox County Medical Society and broadcast each Wednesday from 5:15 to 5:30 over WGIL beginning April 21.

#### **MADISON**

**Society News.**—"The Physician's Opportunity in Tuberculosis" was the subject of Dr. George H. Vernon's address before the Madison County Medical Society at the Madison County Sanatorium, Edwardsville, May 6. Dr. Vernon is superintendent and medical director of the sanatorium.

**Personal.**—Dr. Donald L. Grieme, Troy, was unanimously elected to membership in the Madison County Medical Society April 1.

#### **ROCK ISLAND**

**Society News.**—William Paul, Iowa City, addressed the Rock Island County Medical Society at the Short Hills County Club, East Moline, May 11, on "Physical Medicine and Rehabilitation."

#### **VERMILION**

**Society News.**—Louis R. Limarzi, associate professor of medicine, University of Illinois College of Medicine, discussed "Current Therapy of Blood Disorders" before the Vermilion County Medical So-

cety at the Veterans' Administration Hospital, Danville, May 4. Dr. Samuel M. Feinberg addressed the April 6 meeting of the society on "Food Allergy."

#### **SANGAMON**

**Society News.**—At a meeting of the Sangamon County Medical Society at the Elks Club, May 6, the speakers were Drs. Arthur C. Simon, on "Genitourinary Problems in Childhood"; William Requarth, "Burns in Children", and F. Glenn Irwin, "Abdominal Trauma in Childhood." All are Decatur physicians.

#### **WARREN**

**Personal.**—Harold Swanberg, M.D., Quincy, Secretary of the American Medical Writers' Association, addressed the Illinois State Academy of Science at Monmouth College, Monmouth, May 7, on "Medical Journalism and Writing Courses Now Available—Something New in Collegiate Education."

#### **WINNEBAGO**

**Annual Clinic Day.**—On May 12 the twenty-first Annual Clinic Day was observed at St. Anthony Hospital, Rockford. Speakers were Dr. Ralph E. Campbell, Madison, Wis., on Present Status of X-Ray Pelvimetry; John A. D. Cooper, Chicago, Recent Advances in the Clinical Use of Isotopes; Merle Musselman, Detroit, surgical title not announced; Herman Young, Rochester, Diseases and Injuries of the Back, and Alexander M. Buckholz, Chicago, Precanceroses and Epitheliomas of the Skin. Dr. Lester W. Paul, Madison, Wis., addressed the joint luncheon meeting of the Winnebago County Medical Society and the Winnebago County Tuberculosis Association on "Roentgenologic Aspects of Routine Chest Surveys."

#### **GENERAL**

**Ricketts Medal Goes to Yale Physician.**—The Howard Taylor Ricketts Medal of the University of Chicago was on May 10 awarded to John R. Paul M.D., chairman of preventive medicine, Yale University School of Medicine. Dr. Paul is noted for his studies on poliomyelitis. At the award ceremony, he spoke on "Infectious Hepatitis." The Ricketts medal, honoring the late University of Chicago physician who died of typhus in May 1910, is given by the university in recognition of outstanding medical work.

**Postgraduate Conferences.**—The Postgraduate Education Committee of the Illinois State Medical Society, in co-operation with the staff of Wesley Memorial Hospital, presented a postgraduate conference in Springfield, April 22, 1954. The Sangamon County Medical Society was host.

George A. Hellmuth, M.D., is chairman of the Postgraduate Education Committee, while James C. Leary acts as secretary.

The scientific program consisted of two panels:

Changing Aspects of Thyroid Disease and Its Treatment.

Panelists:

Medical Phases.....Emery C. Grimm, M.D.

Surgical Phases.....T. Howard Clarke, M.D.

Radioisotopes in Thyroid Therapy.....

.....Abram H. Cannon, M.D.

Hypertension in Acute and Chronic Heart Failure.

Panelists:

Pathological Considerations .....

.....Joseph C. Sherrick, M.D.

Medical Management ..Robert J. Hilker, M.D.

Surgical Intervention .....Daniel Ruge, M.D.

Tax and Estate Planning for Professional Men—  
Address John Alan Appleman, A.B., M.A., J.D.,  
Urbana, Ill.

The evening speaker was Charles N. Rush, A.B., J.D., Chicago, member, Kirkland, Fleming, Green, Martin and Ellis, who will speak on "The Trial of Malpractice Cases." Dentists and lawyers, from much of Central Illinois, were invited by the physicians to hear Mr. Appleman and Mr. Rush.

**Doctors and Insurance Men to Discuss Health Insurance.**—A forum on health insurance, with medical men and insurance experts pooling their experience and exchanging views, was held April 14, in the John B. Murphy Auditorium, Chicago.

The conference was sponsored by the Chicago Medical Society and the Health and Accident Underwriters Conference. Walter C. Bornemeier, M.D., president of the Chicago Medical Society, presided.

The four speakers and their subjects were:

John E. Boland, M.D., medical director of North American Accident Insurance Company: "The Interrelationship Between Medicine and Health Insurance."

Charles N. Walker, assistant actuary of the Lincoln National Life Insurance Company: "How Health Insurance Works."

Percy E. Hopkins, M.D., chairman of the voluntary health insurance committees of the Illinois State Medical Society and the American Medical Association: "Insurance Contracts, Patient and Doctor."

L. L. Phelps, assistant vice-president, North American Life Insurance Company; "The Paying of Health Insurance Claims."

**Personal.**—Ann Fox, Secretary of the Educational Committee of the Illinois State Medical Society, was presented with the Mate E. Palmer Award of Merit of the Illinois Woman's Press Association at its annual dinner, May 12. The award signified first place winner for "the best column in a weekly paper" and brought new honors to HEALTH TALK, the weekly publication of the Educational Committee authored by Miss Fox. The issue submitted for the 1954 Annual Contest of the Illinois Woman's Press Association as titled "Our Youth Grows Up." This is the seventh award

given to HEALTH TALK and Miss Fox in the last four years.

## GENERAL

**"Your Doctor Speaks"** over FM Station WFJL. —Since the last issue of the Illinois Medical Journal, the following physicians have appeared in transcribed broadcasts in the series "Your Doctor Speaks", presented by the Educational Committee of the Illinois State Medical Society in cooperation with FM Station WFJL:

**Frederick J. Szymanski**, clinical instructor in dermatology and syphilology, University of Illinois College of Medicine, April 22, The Aging Skin.

**Fletcher Austin**, associate in otolaryngology, Northwestern University Medical School, April 29, Protection of Hearing in Children.

**V. G. Urse**, superintendent, Cook County Psychopathic Hospital, May 6, Alcoholism.

**Harold X. Gerber**, instructor in pediatrics, Chicago Medical School, May 13, Infectious Diseases.

**William A. Larmon**, attending orthopedic surgeon, Passavant Memorial Hospital, May 20, Bursitis of the Shoulder.

**Lectures Arranged Through the Educational Committee of the Illinois State Medical Society:**

**Howard S. Traisman**, Chicago, Jones Commercial High School, May 10, Youth Week Lecture for the Board of Education on Health and Personality.

**Gilbert Lanoff**, Chicago, Oglesby Elementary School, May 13, Youth Week Lecture for the Board of Education, on Teen Age Tips on Health.

**Robert K. Hagan**, Chicago, Harper High School, May 13, Youth Week Lecture for the Board of Education, on Teen-Age Tips on Health.

**C. Edward Stepan**, Chicago, Jungman Branch of the Walsh Elementary School, May 14, Youth Week Lecture for the Board of Education, Keeping Solid with Health.

**Irving Mizell**, Chicago, Canty Elementary School, May 14, Youth Week Lecture for the Board of Education, Teen Age Tips on Health.

**John M. Reichert**, Chicago, Jackson Elementary School, May 14, on Keeping Solid with Health.

**Robert E. Lee**, Chicago, Healy Elementary School, May 14, Youth Week Lecture for the Board of Education, Keeping Solid with Health.

**E. William Immermann**, Chicago, PTA Andrew Jackson School, May 19, on Polio.

**"All About Baby"** over WBKB, Channel 7.—Since the last issue of the Illinois Medical Journal, the following physicians were invited by the Educational Committee to appear in the telecast "All About Baby", a feature on Channel 7, Station WBKB:

**John R. Wolff**, chairman, department of obstetrics and gynecology, Henrotin Hospital, May 5.

**Julius Aronow**, attending pediatrician, Cook County Hospital, May 12.

**Donald E. Cassels**, attending pediatrician, Bobs Roberts Memorial Hospital for Children, May 19.

**Lectures Arranged Through the Scientific Service Committee:** John L. Reichert, Chicago, Lee-Whiteside County Medical Societies in Dixon, July 15, on Unexpected Conditions in Infancy.

Charles N. Pease, Chicago, Whiteside-Lee County Medical Societies in Rock Falls, August 19, on Children's Orthopedics.

## DEATHS

Charles S. Bogardus, Clinton, who graduated at Chicago Homeopathic Medical College in 1897, died February 2, aged 81, of cerebral hemorrhage. He was a member of the Illinois State Medical Society and past president of the DeWitt County Medical Society.

Samuel N. Clark, Jacksonville, who graduated at the College of Physicians and Surgeons of Chicago, School of Medicine of the University of Illinois, in 1909, died May 3, aged 72, of cerebral hemorrhage. He was a member of the Illinois State Medical Society and of the staff of Norbury Sanatorium.

Philip J. Clune, retired, Ottawa, who graduated at McGill University Faculty of Medicine, Montreal, Canada, in 1890, died April 18, aged 85.

George C. Geymer, Chicago, who graduated at the University of Illinois College of Medicine in 1933, died April 14, aged 53. He was a member of the Illinois State Medical Society and of the staff of Illinois Masonic Hospital.

William W. Gourley, retired, Downers Grove, who graduated at the Licentiate of the Royal College of Physicians and Surgeons of Ireland in 1888, died April 23, in St. Charles Hospital in Aurora, aged 89.

Joseph A. Greaves, Chicago, who graduated at the College of Physicians and Surgeons of Chicago, School of Medicine of the University of Illinois, in 1904, died April 18, aged 80. He was a member of the Illinois State Medical Society and had practiced medicine on Chicago's near north side for 48 years.

M. Edward Healy, Chicago, who graduated at Northwestern University Medical Society in 1909,

died May 9, aged 72. He was a member of the Illinois State Medical Society and a navy veteran of World War I.

A. Philip Hess, Chicago, who graduated at Rush Medical College in 1928, died April 23, aged 50. He was a member of the Illinois State Medical Society and chairman of the department of obstetrics and gynecology at the Evangelical Hospital.

Samuel H. Rubinfeld, Abingdon, who graduated at University and Bellevue Hospital Medical College, New York, in 1930, died February 4, aged 48, of coronary occlusion. He was a member of the Illinois State Medical Society, the American Academy of General Practice, Association of Military Surgeons of the United States, and International College of Surgeons.

George H. Schroeder, River Forest, who graduated at the College of Physicians and Surgeons of Chicago, School of Medicine of the University of Illinois, in 1906, died April 25, aged 68. He was a member of the Illinois State Medical Society and, for many years, chief of staff of Lutheran Deaconess Hospital.

Samuel Sprecher, retired, Chicago, who graduated at Illinois Medical College in 1902, died April 19, in Chickasha, Oklahoma, aged 87. He was a member of the Illinois State Medical Society and for many years of the staff of Swedish Covenant and American Hospitals.

Emil J. Viskocil, Lockport, who graduated at Loyola University School of Medicine in 1929, died April 26, aged 53. He was a member of the Illinois State Medical Society and of the staff of St. Joseph's Hospital, Joliet.

John Hartman Ziegler, Farmer City, who graduated at St. Louis College of Physicians and Surgeons in 1905, died January 21, aged 72. He was a member of the Illinois State Medical Society and physician for the Illinois Central Railroad.

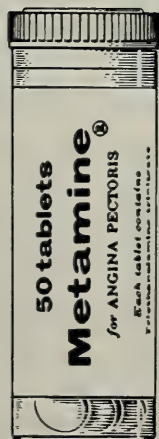
Paul Michael Zilvitis, Chicago, who graduated at the Chicago College of Medicine and Surgery in 1916, died February 22, aged 67.



Numerous clinical and experimental studies since 1946 indicate that METAMINE is ideally suited for routine prevention of anginal attacks because of low (2 mg.) effective dose, prolonged action, and exceptional freedom from side effects. Taken routinely, METAMINE prevents attacks of angina pectoris or greatly diminishes their number and severity.<sup>1</sup> The entire circulation appears to benefit,<sup>2</sup> and the anginal patient may resume a life of useful activity under continuing treatment with this new, low-dose, long-acting coronary vasodilator.

DOSAGE TO PREVENT ANGINA PECTORIS: 1 tablet (2 mg.) after each meal, and 1 to 2 tablets (2 to 4 mg.) at bedtime. Full preventive effect is usually attained after the third day. Bottles of 50 and 500 tablets.

# in prevention of **angina pectoris**



#### References:

1. Palmer, J.H., and Ramsey, C.G.: Canadian M.A.J., 65:16, July, 1951.
2. Pfeiffer, H.: Klin. Wochenschr., 28:304, 1950.

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## BOOK REVIEWS



LIVING WITH A DISABILITY, by Howard A. Rusk, M. D., & Eugene J. Taylor in collaboration with Muriel Zimmerman, O. T. R. and Julia Judson, M. S., The Blakiston Co., Inc., Garden City, New York. 207 pages. 282 illustrations. \$3.50.

This small book is filled with descriptions and pictures of devices that can make living easier for the handicapped person. These devices are without exception very simple in construction and their practicality is evident, when one sees the photograph of the device along side the text describing it. The content covers the use of aids in almost every activity that might be needed in any disability.

There are very few if any other books that cover this subject. These mechanical aids that are described, are for the most part made in the home. No particular item to assist in this or that disability is advertised as made by or sold by "so and so". The ease of construction and the evident practicality of these devices is quite alluring to one perusing the book.

The production of the book is by no means a small procedure. The authors have gathered the material from many sources. The use of the various items has been tried over and over and its value well determined.

This volume will prove very interesting to

physicians, nurses, laymen or to any one having "to do" with the disabled person. To those a bit mechanically inclined it is even very intriguing.

The authors have made available knowledge of existing inventions and discoveries which may help disabled persons find something from which they can "derive greater independence, efficiency, happiness and comfort."

C. P. B.

EXPERIMENTAL ATHEROSCLEROSIS by Louis N. Katz, M. D. Director, Cardiovascular Dept., Medical Research Institute, Michael Reese Hospital, Professorial Lecture in Physiology, University of Chicago and Jeremiah Stamler, M. D., Research Associate, Cardiovascular Dept., Medical Research, Institute, Michael Reese Hospital. 360 page — 46 illustration — 84 tables. Charles C. Thomas, Springfield, Illinois. \$10.50.

The volume deals with the subject as stated in its title. It is very highly technical, and in reporting the work of various scientists that have delved into research on this condition, the explanations are indeed technical and precise. However, the ideas derived from the work of others, as to conclusions touching on the subject,

(Continued on page 50)

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## BOOK REVIEWS (Continued)

is set forth in very readable manner. The meaning of Athersclerosis is well established as to its definition and as to varieties. Premises are laid down in the early portion. These leave an enormous breadth for experimental work toward a conclusion. Many of the barriers arising in pursuit of this subject are noted and explained. This one portion may justify the publication.

From this study and it was very extensive, it is determined that the chick is "the" only available organism for satisfactory experimentation of Athersclerosis.

Why this is true is dealt with at the beginning of the 4th chapter. Then follows the question of similarity of these specific lesions in the chick to those in the humans.

Whether or not quantitative relationships can be demonstrated between Cholesterol and Atherogenesis, is then given space and is well considered.

Another consideration is "do dietary factors influence experimental Atherosclerosis". The reply to this is given full consideration. And

logically, next comes the endogenous factors influencing Athersclerosis.

After other pertinent facts are gone over, the question is "can experimental Athersclerosis be induced without gross Hypercholesterolemia and organ Lipidosis?"

This book deserves consideration from all research workers. It certainly spot-lights for the practicing Internist some facts and fallacies on a question not yet concluded but gaining in interest on a clinical entity in which we are all necessarily interested.

C. P. B.

**MUSIC THERAPY.** Edited by Edward Podolsky, M. D., Department of Psychiatry, Kings County Hospital, Brooklyn, N. Y. Published by Philosophical Library, 15 East 40th Street, New York, Copyright 1954. Price \$6.00

Music Therapy is over 4,000 years old. It was used by the Egyptians and Persians. In the Old Testament, it is recorded that King Saul was benefited by music when his mind began to disintegrate. "When the evil spirit from God was

(Continued on page 52)

## "A program of treatment for *chronic ulcerative colitis*...

as described by Lester M. Morrison, M.D., Los Angeles<sup>1</sup>

... is based on the use of 1) azopyrine\*, 2) ACTH or cortisone and 3) psychotherapy."

"Azopyrine\* ... has been effective in controlling the disease in approximately two-thirds of patients who had previously failed to respond to standard colitis therapy currently in use."

1. Rev. Gastroenterology 20:744 (Oct.) 1953; abstract in J. A. M. A., 153:1580 (Dec. 20) 1953.



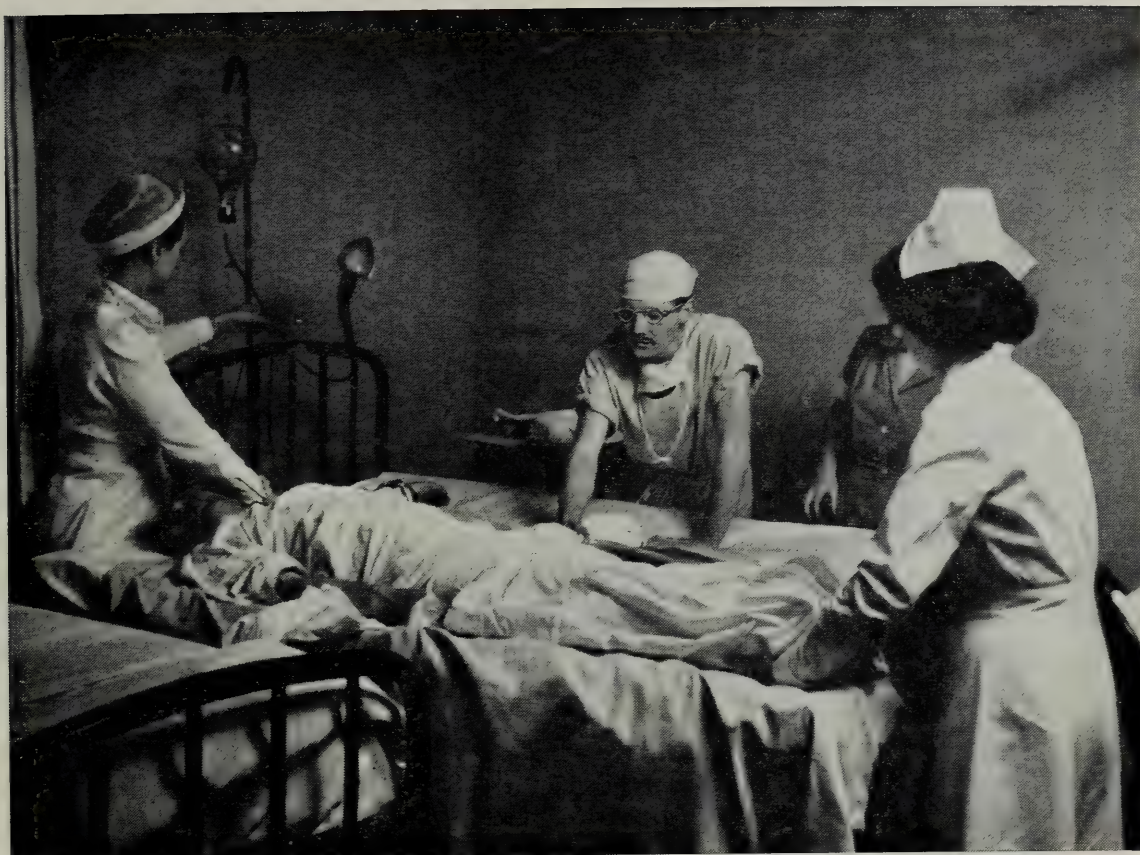
\* *now available under the name ...*

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Riboflavin .....	10 mg.
Niacinamide .....	100 mg.
Pyridoxine Hydrochloride .....	2 mg.
Calcium Pantothenate .....	20 mg.
Ascorbic Acid .....	300 mg.
Vitamin B <sub>12</sub> Activity .....	4 mcg.
Folic Acid .....	1.5 mg.
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## BOOK REVIEWS (Continued)

upon Saul, then David took up a harp and played with his hands so that Saul was refreshed and well, and the evil spirit departed from him." Throughout history are found many examples of the beneficial effect of music upon ill and distraught patients.

Towards the end of the 18th century, the first serious effort to evaluate the effects of music on the human mind were made by Dr. Brocklesby. Dr. D. T. Wimmer, in 1890, used piano music on 1400 mentally ill women. He reported all showed improvement.

This book attempts to evaluate the effect of music therapy as practiced today. It consists of thirty-two chapters most of which have appeared originally in scientific journals. The application of music therapy in medicine covers many fields of psychiatry, surgery and military medicine.

This text has an excellent bibliography, but no index.

**CURRENT THERAPY** Edited by Howard F. Conn, M. D., Consulting Editors. M. Edward Davis, Vincent J. Derbes, Garfield G. Duncan, Hugh J. Jewett, William J. Kerr, Perrin H. Long, H. Houston Merritt, Paul A. O'Leary, Walter L. Palmer, Hobart A. Reimann, Cyrus C. Sturgis, Robert H. Williams. Published by W. B. Saunders Company, Philadelphia & London. Copyright 1954.

Because this textbook covers so well the field of general medicine concisely, practically, and systematically, it is no small wonder that this 6th edition is eagerly awaited by many busy general practitioners.

It is a huge volume of almost 900 pages divided into 16 sections with a veritable host of qualified contributors. The management of each disease state is logically developed. When deemed necessary the therapeutic regimen of more than one physician is presented. A drug roster, a table of metric and apothecaries systems, and tables for making percentage solutions are in-

*(Continued on page 54)*

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benefit from the tranquilizing,  
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and 0.1 mg.

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2f 2013M

## BOOK REVIEWS (Continued)

cluded toward the back of the book. The index, printing paper and binding are satisfactory.

Because the book is so large and heavy, it would be interesting to know if it would be feasible to print it with smaller type and thinner paper to the end that a more manageable book would obtain.

### BOOKS RECEIVED

The following books have been received for reviewing, and are herewith acknowledged. This listing should be considered as a sufficient return for the courtesy of the sender. Books that appear to be of unusual interest will be reviewed as space permits each month. Readers desiring additional information relative to books listed, may write the Editor who will gladly furnish same promptly.

FRENCH'S INDEX OF DIFFERENTIAL DIAGNOSIS. Edited by Arthur H. Douthwaite, M.D., F. R. C. P., Senior Physician, Guy's Hospital; Honorary Physician, All Saints' Hospital for Genito-urinary Diseases. 7th Edition. With 73 illustrations, of which 200 are in colour. The Williams and Wilkins Company, 1954. \$20.00.

SONG OF LIFE WITH VARIATIONS. By H. Ameroy Hart-

well, M.D. Bruce Humphries, Inc., Boston, publishers. \$5.00.

THEORY AND PROBLEMS OF ADOLESCENT DEVELOPMENT. By David P. Ausubel, M.D., Ph.D., Bureau of Educational Research, University of Illinois, Champaign. Grune & Stratton, New York. Price \$10.00.

THE ECZEMAS — A Symposium by Ten Authors. Edited by L. J. A. Loewenthal, M.D., M. R. C. P., D. T. M. & H. E. & S. Livingstone, LTD., Edinburgh and London, 1954. \$7.50.

Annals of the New York Academy of Sciences. Volume 56, Art. 7. "Mathematical Deductions from Empirical Relations Between Metabolism, Surface Area and Weight," by Hermann von Schelling. 22 pages, illustrated. Price \$1.00.

Annals of the New York Academy of Sciences. Volume 57, Art. 4, "Branched Molecules," by F. R. Eirich and 18 other investigators. 135 pages, illustrated. Price \$3.50.

Annals of the New York Academy of Sciences. Volume 57, Article 5, "Parental Age and Characteristics of the Offspring," by L. C. Strong and 21 other experts. 150 pages, illustrated. Price \$3.50.

Annals of the New York Academy of Sciences. Volume 58, Art. 1, "Neurotoxoid Interference with Two Human Strains of Poliomyelitis, in Rhesus Monkeys," by Murray Sanders et al. 12 pages, illustrated. Price \$.50.

#### • Bodansky

...there is probably no other common disorder (obstinate constipation) which is so often badly mismanaged...The most important principles of management are:...and 3) stopping the use of strong laxatives and enemas.

#### • Shallenberger & Kerr

...bile per se is stimulating to the movements of the bowel so that an increase in bile flow has a *natural* stimulating effect.

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- Bodansky & Bodansky: Biochemistry of Disease, 2nd ed., 1952, p. 337.
- Shallenberger, P. L. & Kerr, P. B.: Postgrad. Med. 13:32, 1953.

## TREATMENT OF REGIONAL ILEITIS

When we are dealing with the advanced stage of regional ileitis with ulceration and obstruction the only hope for cure is radical excision of the diseased bowel. It is generally felt that if at laparotomy the disease is recognized in the early stage, primary resection should probably not be carried out. There are two reasons for this, one because the disease may regress and two because resection in the acute phase seems to carry a higher mortality. Some investigators say that even the appendix should not be removed because of the tendency to fistula formation. Two years ago I operated on a man with a diagnosis of acute appendicitis who had an early terminal ileitis. An appendectomy was performed and an uneventful recovery ensued. The patient has been well since then, his only complaint being occasional mild diarrhea. However, in my mind it seems that early primary resection might prevent some of the recurrences. In the chronic stage, several surgical procedures have been recommended. The simplest one is an ileocolostomy without exclusion. The mortality with this is low but the return of symptoms is high. Ileocolostomy with exclusion has given good results, but the diseased bowel is still left behind with this operation. A Mikulicz resection has been performed at the Lahey Clinic with good results. Recently there has been a definite tendency to carry out ileocolostomy and primary resection of the diseased bowel. The mortality figures in some series is as low as two percent. Of course the final decision as to the type of surgery rests with the individual case. However, with adequate preoperative preparation, careful surgical technic, and good postoperative care, a one stage resection may be carried out safely. *Richard T. Munce, M.D., Bangor, Maine, Regional Ileitis. J. Maine M.A., December, 1953.*

Close correlation between social disturbances and mortality rates suggests that in most civilized communities large number of tuberculous patients live in unsteady equilibrium with their disease and survive only as long as a peaceful, comfortable, and protected environment is provided for them. *Rene J. Dubos, Ph.D., Am. Rev. Tuberc., July, 1953.*

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## DIABETES AND TUBERCULOSIS

*By Elmer S. Gais, M.D., New York State Journal of Medicine, August 15, 1953.*

Tuberculosis occurs frequently as a complication of pre-existing diabetes mellitus. The fact that this combination of diseases is lethal unless recognized early and treated vigorously is of utmost importance. The incidence of tuberculosis is higher in the diabetic than in the general population. Recent evidence is presented by the Philadelphia Survey in which 8.4 per cent of the 3,106 diabetics studied were tuberculous, whereas 4.3 per cent of a group of 70,767 industrial workers were found to harbor tuberculosis.

From this survey other important conclusions were drawn: (1) tuberculosis was *active* in 2.6 per cent of the diabetics and was three times as prevalent in those under 40 years of age as in those 40 or over; (2) the prevalence of active tuberculosis increased markedly with severity of the diabetes and was greater in underweight persons than in overweight; (3) in the younger age group the prevalence of active tuberculosis was much greater in those having had diabetes 10 years or more; (4) tuberculosis was much more likely to be in active diabetics than in non-diabetics.

No conclusion was reached as to the effect of degree of control of diabetes on the incidence of tuberculosis. The juvenile diabetic at present survives into the decades when tuberculosis becomes more prevalent; thus the opportunity for exposure and increased incidence of tuberculosis becomes a function of time itself. If underweight is evidence of undernutrition and inadequate control, then the increased incidence in this group may reflect the hazard of poor diabetic control.

A statistical case for the beneficial effect of improved diabetic care can be made by a comparison of the declining mortality of the diabetic from tuberculosis in the various eras of diabetic therapy, which seems to be related to the longer lasting insulin effect with better control. However, the effect of improved treatment of tuberculosis must be evaluated, particularly since the overall mortality from tuberculosis is declining more rapidly than that from diabetes.

From a presently incomplete study of several

*(Continued on page 60)*

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## DIABETES (Continued)

hundreds of tuberculosis diabetic patients treated in Montefiore Hospital, (N.Y.), under uniform supervision over the past 15 years, it appears that more thorough control of the diabetes yields a definitely higher survival rate, *almost equaling the survival rate of the nondiabetic tuberculous patient in the same institution receiving the same therapy for his tuberculosis.* This conclusion is tentative and may have to be modified somewhat in the light or stricter analysis.

What is the reason for the increased susceptibility of the diabetic to infections, in this instance, tuberculosis? Many theories have been advanced, among the latest of which is the effect of adrenal steroids on the immune reaction in tuberculosis. Overproduction of such contra-insulin steroid or pituitary factors, particularly in the older age group of diabetics, may well be a determining factor in the causation of diabetes and of altered immunity. This might also explain the high incidence of true insulin resistant diabetes in tuberculosis. But in the younger age group of diabetics, deficiency of insulin

itself seems to be the prime cause of diabetes. Yet this age group has a high rate of active tuberculosis. Further studies may resolve this dilemma.

The course of tuberculosis in the diabetic is usually stated to be more active, more progressive and leading to more frequent generalized spread. Many features of the pathology of the disease warrant this conclusion. Fewer, less dense pleural adhesions, rendering pneumothorax easier, less fibrosis, more caseation and a low incidence of amyloid disease, attest to the more rapid progress of the disease. There seems to be no difference in native immunity to tuberculosis in diabetics. Healed primary lesions are usual. But something occurs after development of diabetes which lowers the normal resistance to tuberculosis infection, and the disease may progress rapidly.

There is no essential difference in the localization of the tuberculous infection in the diabetic and the nondiabetic. The onset is no more insidious, but it is very often missed. The old rule that "in every diabetic who is not doing

(Continued on page 62)



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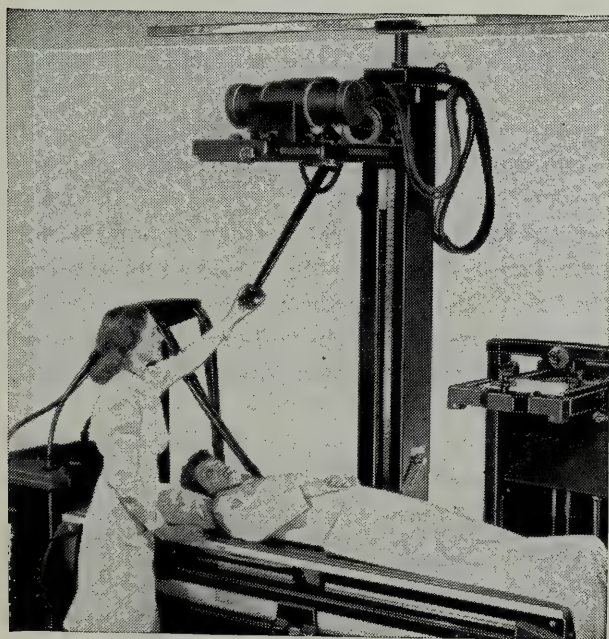
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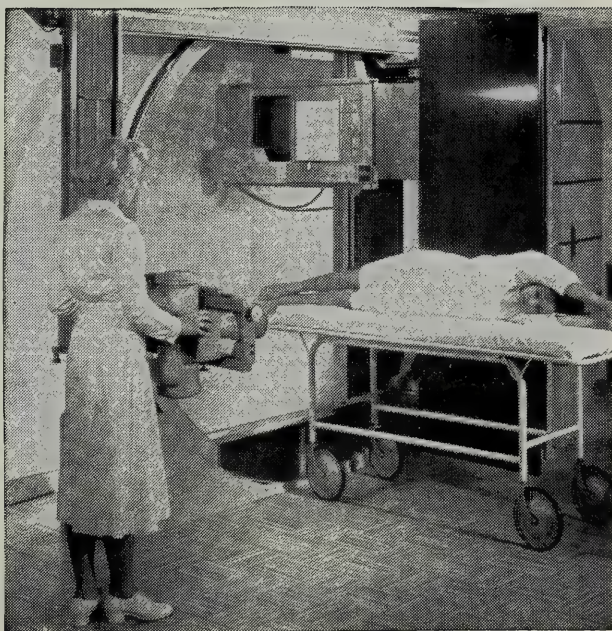
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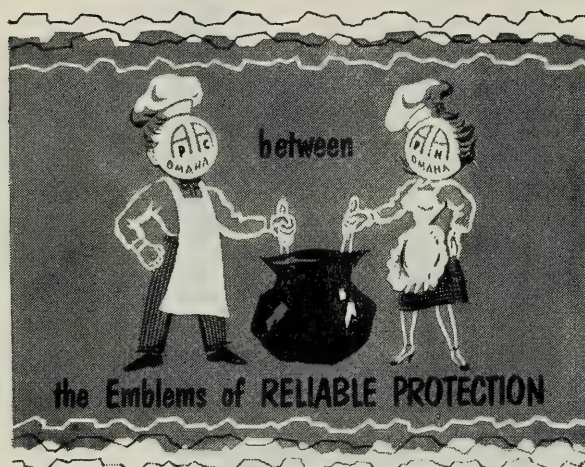
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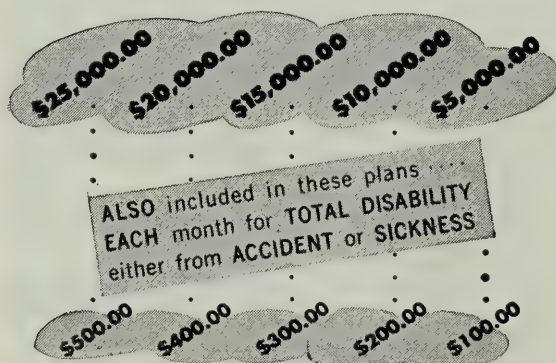
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## DIABETES (Continued)

well without apparent cause, suspect tuberculosis" still holds. The minimum of a semi-yearly roentgenogram of the chest is a small price to pay for early diagnosis! It is well to remember that tuberculosis may become active very frequently in the older age groups as well as in the younger.

At Montefiore Hospital there is no limitation placed on the treatment of the tuberculous patient because he has diabetes. Under proper management there is no reason to fear ketosis. Premature vascular disease in a diabetic may preclude extreme surgical procedures. But, by and large, these patients can be treated for tuberculosis almost as if the diabetes did not exist. Chemotherapy is used according to the newer concepts. The possible increase in insulin requirement resulting from isoniazid therapy is offset by the decrease from the improved febrile state, so that diabetic balance is maintained. The important principle is to treat the disease vigorously. All diabetic subjects who develop tuberculosis should be hospitalized immediately in an institution equipped to treat both diseases.

The diabetes should be treated to maintain adequate nutrition in a chronic, debilitating, febrile disease. The diabetes is rendered more severe as a rule, but a satisfactory degree of stabilization occurs even with the fluctuating course of the infection. The diet should be attractive and varied. Over- or underweight should be avoided. Most patients on enforced bed rest tend to become overweight. The vascular, neuropathic, and other complications of diabetes when encountered are treated in the usual manner.

Insulin is necessary in at least 95 per cent of the patients. The longer-lasting insulins are quite satisfactory but frequently must be supplemented. With the fluctuations in the infectious process minimal glycosuria and near normoglycemia are often difficult to accomplish, but with constant vigilance can nearly be attained. Fractional urines are used as the base for regulation, and even a slight ketosis is treated vigorously. We have had no deaths from diabetic coma.

A few practical points may be mentioned.

(Continued on page 64)

# When in the judgment of the physician...

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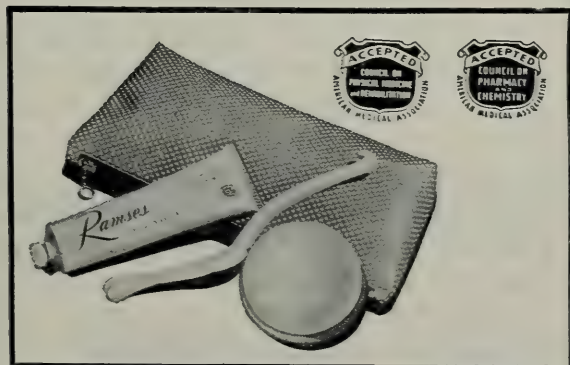


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## DIABETES (Continued)

Re-adjust the insulin dosage slowly. Fluctuations in the infection, changes in appetite, and the tendency for long-institutionalized patients to relax their regimes are factors in control. Above all, avoid hypoglycemia with its attendant danger of unconsciousness and aspiration of infected material with bronchogenic spread. A slight glycosuria will avoid this hazard. Whenever a persistent aglycosuria occurs, it is wise to reduce the insulin dosage promptly but gradually.

With vigorous therapy, a hopeless outlook is no longer necessary. Preliminary uncorrected analysis of the first 100 of the cases in Montefiore Hospital from 1936 to 1941 shows a five-year mortality rate of 24.2 per cent against a rate of 22.9 per cent of nondiabetic tuberculous patients. This is also evidenced by the increasing number of discharges of arrested cases, who are an excellent group of well-controlled diabetics.

The watchwords are early detection and prompt, vigorous treatment of both diseases.

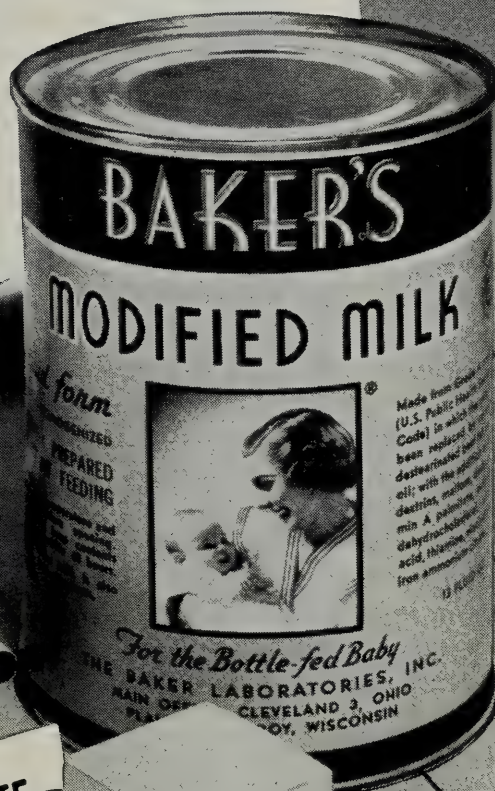
(This abstract was prepared from one of the articles entitled "Current Concepts in Diabetes Mellitus" published under the auspices of the Committee on Professional Education of the Clinical Society of the New York Diabetes Association.)

## THYROID CANCER

Goiter of all types is much more prevalent in the female, although the rate of occurrence of carcinoma in men with nodular goiter is increased over that of women. Ward reported a ratio of one man to seven women in benign nodular goiter but a ratio of one man to 3.5 women in thyroid carcinoma. Stating this in another way, a man's chance of having cancer in his nodular goiter is almost three times that of a woman's. The actual number of men with thyroid carcinoma reported in all series of cases is less than that of women but the rate of cancer in men with nodular goiter is much greater. There is one thyroid cancer to every 17 surgical goiters in men, whereas in women there is one thyroid cancer to every 44 surgical goiters. William Trevor, M.D., *Thyroid Cancer*. *New York J. Med.* Nov. 1, 1953.

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in poisoning by heavy metals such as mercury, bismuth, uranium, and phosphorus; organic compounds such as carbon tetrachloride, alloxan, cresol, uric acid, mushroom, and black widow spider poisons; crystallization from or sensitivity to sulfonamide drugs, toxicity of antibiotics and infectious agents such as leptospira, staphylococci, meningococci, etc. *George E. Schreiner, M. D., Acute Renal Insufficiency (Editorial). M. Ann. District of Columbia, Nov. 1953.*

In 1949, the chiefs of field party (Institute Inter-American Affairs) had been requested to furnish a list of the 10 diseases which were considered the most serious public health problems in the countries in which they were resident. . . . A total of 35 different diseases were enumerated as major health problems in the 13 lists returned. Of these only one disease, tuberculosis, appeared in all the lists . . . malaria in 11, and whooping cough in 10. No other disease approached such unanimity except measles, which was included in eight lists. Institute of Inter-American Affairs, Pub. Health Reports, Nov., 1953.

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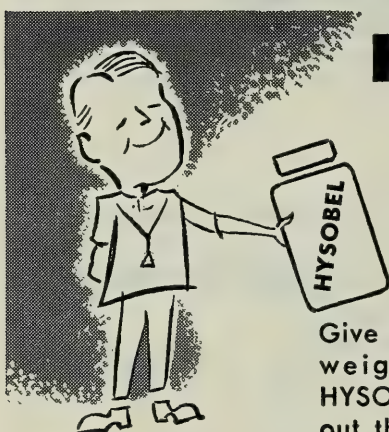
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## HOME CARE OF TUBERCULOSIS

I should like to make a few comments relative to home care of tuberculosis. As you are well aware, the advent of new drugs has been followed by considerable demand on the part of patients for home care. Recently I attended a discussion on the subject of home care versus sanatorium care where home care was discussed only in two aspects: first, in the period awaiting a hospital bed, and, second, as a method of getting more hospital beds by permitting earlier discharge from the hospital. All the speakers believed that hospital care was necessary at some period for every patient with active tuberculosis, and I agree. The problem is much broader than that of medical treatment alone. If the patient has a positive sputum, he is a source of infection to others, and he should be in a hospital during this period. Most homes do not have the proper physical facilities for the care of a patient, and most families cannot adjust themselves to spend the time, effort, and money that is necessary to

provide the proper mental and physical rest for the patient. The team for home care should consist of the physician, the public health nurse, and the social worker; these in turn must be aided at certain stages of the patient's care by teachers, occupational therapists, and sometimes by rehabilitation workers or vocational counselors. When one looks at the problem from all these aspects, one can see that home care can be a very expensive program. Home care is an important adjuvant to hospital care but must be carefully co-ordinated in order to achieve the maximum medical and rehabilitation benefits. In answer to the more common belief that patients will be more content at home, I am convinced that patients can become content in a tuberculosis hospital if the hospital standards are high and if proper attention is given to the interpersonal relationships of the hospital personnel and the patients. *Frederick Beck, M.D., The Role of Antibiotic Drugs in The Treatment of Tuberculosis. New York J. Med., Oct. 15 1953.*



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## SHOULD IT REMAIN A TABOO SUBJECT?

If the physician will school himself to drop the cloak of embarrassment, a taboo carried over from childhood, and face the physiology of sexual activity in the same spirit as that of the cardio-respiratory or gastro-intestinal system, he will be surprised at what some of his patients wish to discuss and what questions they will ask. He need not, indeed must not, pry into private and intimate matters if the patient does not wish this done. At times, however, he need give the patient only half a chance to burst a dam of questions and complaints. A routine and perfectly proper question in the System Review of the history under the heading of the genito-urinary system may open the closet door for the patient to let in the light. In the unmarried, a simple, "Do you have any sexual problem or worries?", in the married merely a, "Do you and your husband (or wife) have a satisfactory sexual life?", are questions for which there can be no criticism or to which the patient cannot object. The patient may answer with a "No"

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or a "Yes," and the matter may be dropped, or the patient may seize the opportunity to unload years of secret worries and unanswered questions. It is shocking to learn how often the patient adds, — "This is the first time a doctor has ever given me a chance to talk about this," or "I've tried to talk to my doctor about this but he has been too busy to listen," or "he did not want to listen," or "I am glad I've had a chance to talk about this. I've known my doctor so long I couldn't bring myself to talk this way." What an indictment of the medical profession! *Editorial, J. Tennessee State M.A., December, 1953.*

June, 1954

The adult and older men, who constitute today the most important reservoir of infection, are also the group least readily reached by screening programs and least able or most reluctant to abandon their ordinary occupations for the purpose of seeking segregation and treatment in sanatoriums and other tuberculosis hospitals, Rene J. Dubos, Ph.D., Am. Rev. Tuberc., July, 1953.

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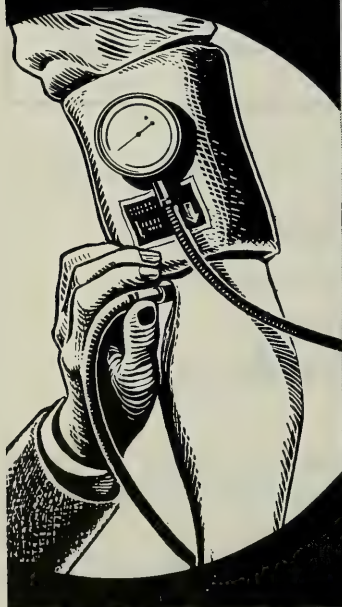
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## THE DOCTORS WHO SURRENDERED

The source of greatest weakness in the doctors' position is the fact of their readiness to compromise. A minority of them actually advocates compulsion, and even the majority is willing to co-operate, if only on its own terms. That makes them suspected, of course. Instead of taking the position of principle, they argue about technicalities and honoraria, overlooking the public reaction. They overlook two more things, as a rule. Once the principle of compulsion is accepted, the amount and terms are not being determined by the doctors or upon their advice. And even if the terms conform at the outset with the professional proposals, the schemes expand sooner or later far beyond the original intent.

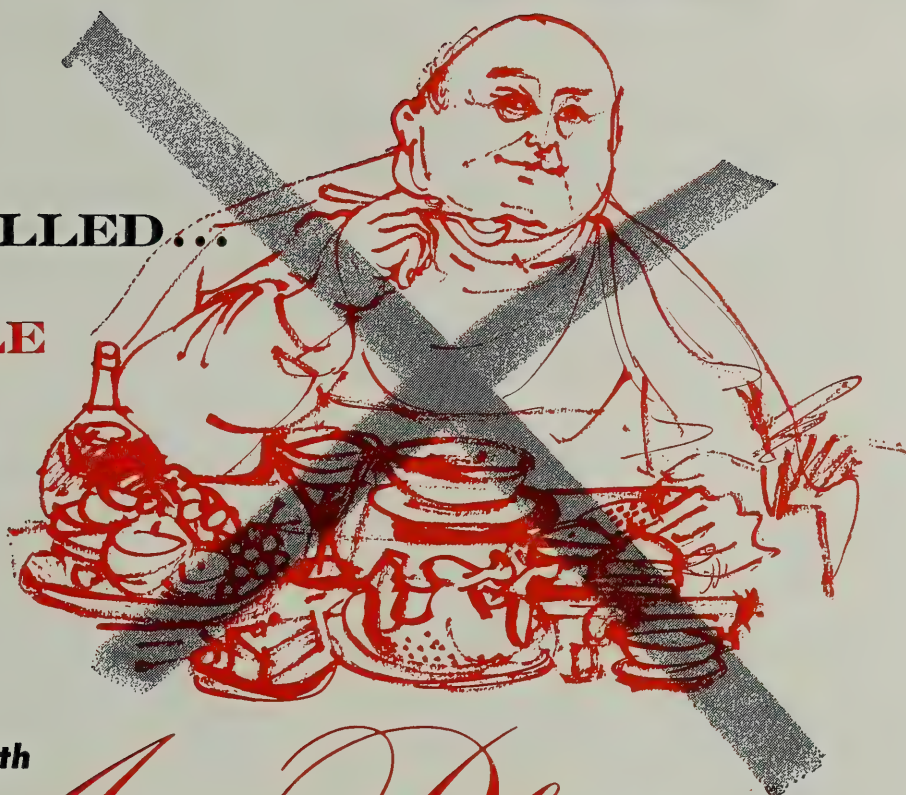
In the recent case of Britain, one reason why the doctors' resistance broke was the fact of defection in the medical ranks themselves. When it came to the showdown on the Bevan scheme, 35 per cent of the profession, including the top leadership of the British Medical and Dental Associations, capitulated. (A chief executive of the latter has been promptly promoted to a high rank in the Ministry of Health.) But the majority was railroaded into submission by the threat that those who did not sign on the dotted line would lose all claim to compensation for the capital value of their practices. Nearly 19,000 out of 21,000 doctors and 9,000 out of 10,000 dentists have signed up. (The latter were lured into the scheme by the prospect of unprecedented incomes — which are fading out gradually.) The moral of this story is that in the final analysis the doctors can blame themselves if they lose out — if their incomes are reduced at once by 25 per cent of the average, as under Bevan, and their professional standard lowered in an unmeasurable fashion — just as a nation can blame itself if it foregoes its liberties, be it by submitting to intimidation or by letting itself be bribed into "collaboration." *Editorial, Doctors' Surrender. Compulsory Medical Care and the Welfare State by Melchior Palyi.*

No drug having been thus far found in the treatment of tuberculosis which kills all tubercle bacilli, the objectives of drug treatment in this disease still fall short of the eradication of all infecting organisms. William B. Tucker, M. D., *Annals of Internal Med.*, Nov., 1953.

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**July — December, 1954**

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# *The* ILLINOIS *Medical Journal*

Official Journal of the Illinois State Medical Society

Harold M. Camp, EDITOR.

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Vol. 106, No. 1

July, 1954

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## Evaluation of Gamma Globulin Prophylaxis of Poliomyelitis in 1953

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National Advisory Committee for Evaluation of Gamma Globulin.

Springfield

### *I. Introduction*

With the demonstration by Hammon and co-workers<sup>1a,b,c,d</sup> of a significantly lower paralytic poliomyelitis attack rate among gamma globulin inoculated groups, as compared to the rate for gelatin inoculated children, the major portion of the limited national supply of gamma globulin was allocated for poliomyelitis prophylaxis under the terms of a new historic series of directives and uniform rules of distribution. Circumstances dictated such allocation despite the voiced opinions of many able scientists that the work of Hammon, with its statistically significant difference between 31 cases among 27,386 children inoculated with gamma globulin and 73 cases among 27,386 children receiving gelatin inoculations, should be repeated a sufficient number of times to determine the reproducibility of the results.

Hammon himself had called attention to the impracticality of a method of prophylactic application which required from 300 to 2,000 inoculations to prevent 1 case of paralytic poliomyelitis. Furthermore, the method of mass prophylaxis to be applied judiciously was dependent upon statistical techniques of prediction

of incidence which, at best, were quite faulty for local area application, not only from the standpoint of incidence, but also from the standpoint of rigid geographic definition. In this regard, Hammon<sup>1d</sup> had also stated: "While our studies were carried out in two very severe epidemics and in a third that had unusually high rates for a large city, it is unlikely that similar situations could be selected with any predictable regularity."

Opponents of this technique of application proposed the use of gamma globulin prophylaxis among household contacts of poliomyelitis cases; fully realizing that multiple cases in families occur in less than 5% of instances, that 60% of such subsequent cases develop within the first 5 days after onset of the index case, 30% between 6 and 12 days and 10% at intervals longer than 12 days. It was hoped, however, that gamma globulin administered to household contacts immediately following diagnosis of the first case in the family would modify the severity of a significant number of subsequent cases among the 30% and prevent a good proportion of the cases among the 10% which have their onset interval prolonged either because of prolonged incubation periods following concur-

rent infection with the index case, or because infection may occur at varying intervals after the first case. Suffice it to say that both methods of application became the pattern of gamma globulin use in 1953.

Organization of a program of evaluation of the efficacy of gamma globulin as actually used was instituted under the auspices of the U. S. Public Health Service, with the assistance of a National Advisory Committee. A summary of this organization, the study plan and conclusions have been published elsewhere<sup>2</sup>, but it is believed that pertinent details are worthy of note here to acquaint Illinois physicians and health officers with the background for present plans of distribution of gamma globulin for poliomyelitis and afford them the facts upon which they may base their personal decisions for such use. The complete, extensively detailed analysis of the results of this evaluation will appear as a Public Health Service Monograph<sup>3</sup>.\*

## II. Mass Prophylaxis

### A. Evaluation of Prevention

Since the opportunity to repeat Hammon's work no longer presented itself in 1953, the analysis of the preventive value of mass prophylaxis in 1953 was admittedly not based upon purely experimental field data with rigid controls.

The analysis rather involved a hunt for consistent deviations from classical epidemiological patterns in mass inoculation areas in the belief that a marked preventive effect might be observed. Four approaches were available to the evaluating group: (1) Asymmetry of the epidemic curve for the inoculated age group; (2) Age-shift of cases to older age groups following mass inoculations; (3) Modification of the duration of the epidemic; and (4) Differences in paralytic attack rates between inoculated and uninoculated children in the eligible age group.

#### 1. Asymmetry of Epidemic Curve

It has frequently been noted that large-scale epidemics of poliomyelitis tend to occur in symmetrical form. Since the preventive effect of gamma globulin, according to Hammon's data, begins about one week after its administration and persists until about the fifth week, mass inoculations administered at or near the peak of an epidemic would be expected to produce

consistent, rapid declines in the epidemic curve. The epidemic curves for the 23 areas receiving mass inoculations in 1953 were first screened for evidence of continuation of the epidemic among the uninjected age group, utilizing an arbitrary minimum of 6 cases occurring in this group after the first week following mass inoculations. A second screening criterion involved the occurrence of at least 12 cases among the eligible age group in the period prior to mass inoculation. In this manner 10 counties receiving mass inoculations and having fair-sized epidemics were found suitable for study of asymmetry. Similarly, 9 other counties which satisfied these criteria and which had met critical-incidence criteria under the O.D.M. formula, but without mass inoculation experience, were selected for comparison. All 19 epidemic curves for the eligible age groups were reproduced by a referee and submitted to the Subcommittee on Mass Prophylaxis, unlabeled and without reference as to gamma globulin inoculation. Members of the Subcommittee then classified the curves according to symmetry and only after completion of such classification were they sorted according to type of curve and presence or absence of mass inoculation.

TABLE 1

Distribution of Counties With Poliomyelitis Outbreaks According to Administration of Mass Prophylaxis and Configuration of Epidemic Curves  
United States 1953

Type of Epidemic Curve	Number of Counties	
	Mass Prophylaxis	No Mass Prophylaxis
Symmetrical .....	2	3
Left Skew .....	4	1
Right Skew .....	3	2
Unclassifiable .....	1	3
Total .....	10	9

Table 1 presents a summary of the findings of this analysis of symmetry. It will be noted that for both counties receiving mass inoculation and not receiving mass inoculation, all types of epidemic curves were present. Of the 4 epidemic curves with left-skewness, which might be attributed to a globulin effect, only Macon County, Illinois administered gamma globulin in the week prior to the peak of the epidemic in the inoculated age group (Figure 1) and only Caldwell County, North Carolina and Montgomery County, Alabama administered globulin as early as the end of the first week following the peak of the epidemic curve. Montgomery County not

\*Tables 2 to 9 inclusive and Table 11 presented herein are from the National Advisory Committee's report.

FIG. 1

## MACON COUNTY GAMMA GLOBULIN MASS PROPHYLAXIS-1953

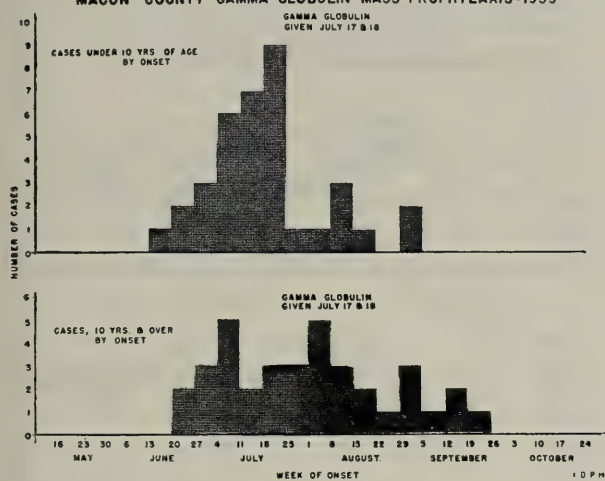
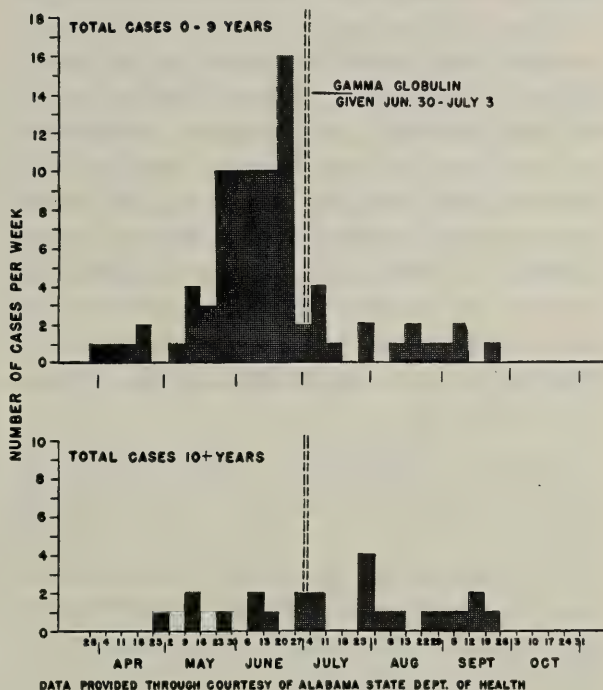


FIG. 2

POLIOMYELITIS  
MONTGOMERY COUNTY, ALABAMA  
1953  
BY AGE AND WEEK OF ONSET

only had the most pronounced left-skewness, but actually revealed its abrupt decline in cases in the week prior to the administration of gamma globulin (Figure 2). Furthermore, three mass prophylaxis area curves actually revealed right-skewness, a phenomenon not foreign to poliomyelitis epidemic curves. Figure 3 demonstrates the character of this type of curve in one of three mass prophylaxis counties and indicates the time of administration of gamma globulin.

FIG. 3

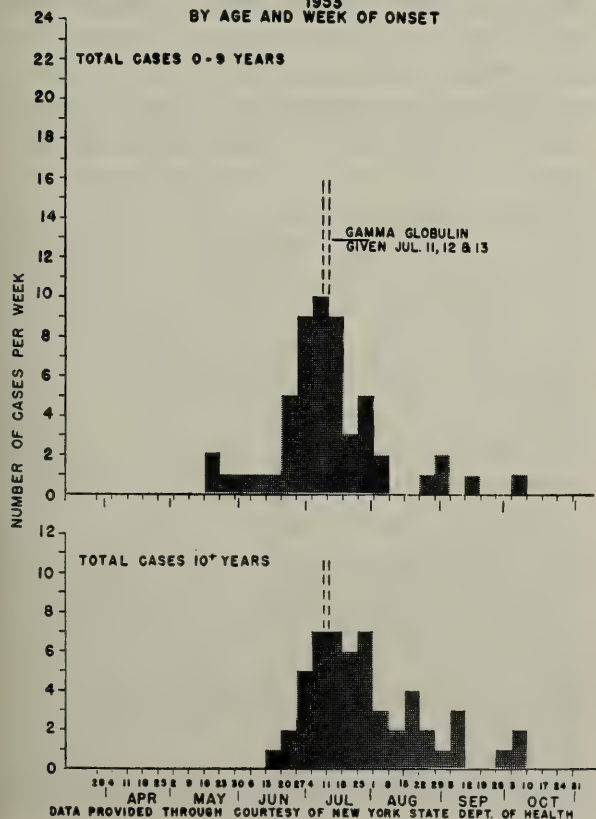
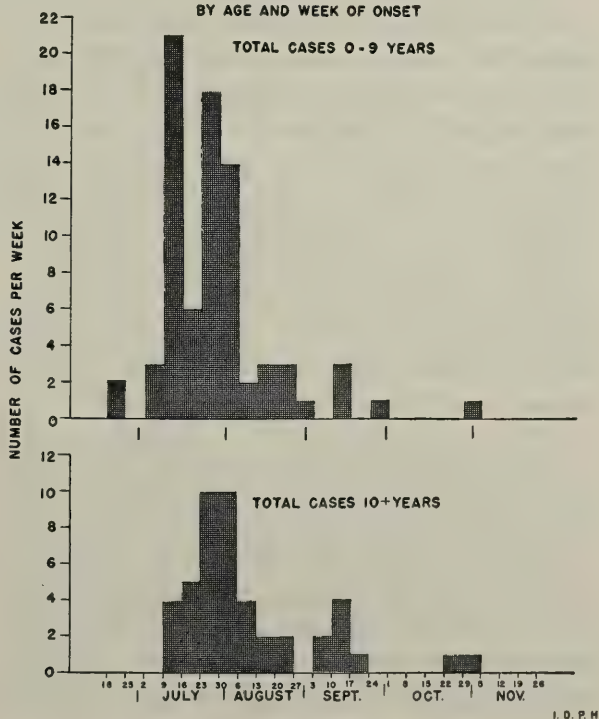
POLIOMYELITIS  
STEBEN COUNTY, NEW YORK  
1953  
BY AGE AND WEEK OF ONSET

FIG. 4

POLIOMYELITIS  
MARION COUNTY, ILLINOIS  
1949  
BY AGE AND WEEK OF ONSET

An analysis of 14 county outbreaks of poliomyelitis in Illinois from 1948 to 1953, ranging in size from 52 to 169 cases and representing high population attack rates, revealed a similar distribution of the several types of epidemic curves for age groups under 10 years. In at least 4 of them (Champaign and Marion in 1949; Coles and Lake in 1952), left-skewness, with abrupt declines following one or more weeks of high incidence, was noted and these areas did *not* experience mass inoculations. The Marion County outbreak in 1949 (Figure 4) could also have served as an example of globulin effect on the basis of the shape of its epidemic curve, if globulin had been administered during the week ending July 30.

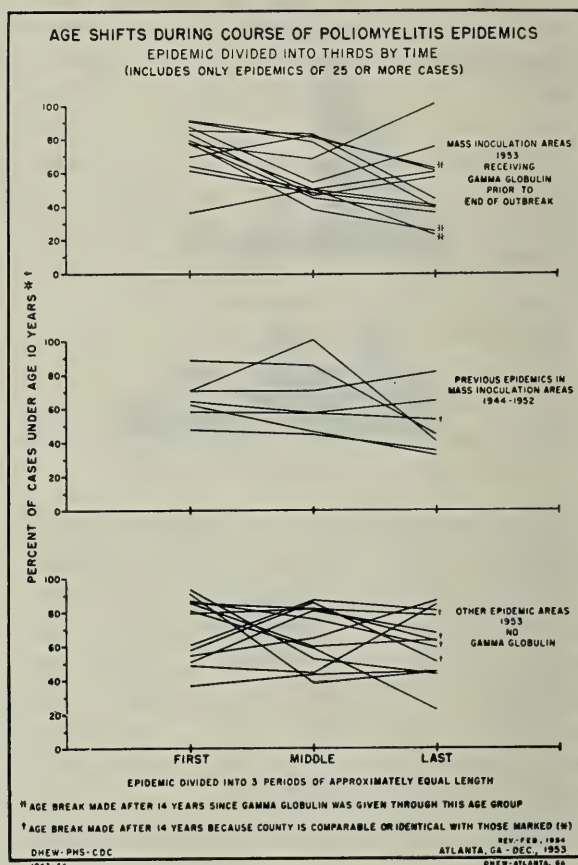
Thus, from this type of evidence and its extreme variability among both inoculated and uninoculated areas and without consistent differences between the two groups as summarized in Table 1 above, the observed left-skew asymmetry among several counties receiving globulin inoculations in 1953 could not be attributed to a gamma globulin effect.

## 2. Shift in Age Distribution

It was postulated that, if gamma globulin has a preventive effect, inoculation of one age group near the peak of an outbreak should produce a decline in incidence in that age group, whereas the incidence among the uninoculated age group would become relatively greater from about one week after mass inoculation onward. The incidence data for mass inoculation areas in 1953 was examined for such age shifts, utilizing only those areas with outbreaks of 25 cases or more and in which gamma globulin had been given prior to the end of the outbreak. Intra-epidemic trends in such areas were compared with trends of previous epidemics in the same areas in the years 1944-1952 and with other epidemic areas in 1953 which did not receive mass inoculations.

Epidemics among these several counties were divided into thirds — first, according to time, i.e., into three equal time periods; and then according to cases, i.e., into three equal size groups of patients at the beginning, the middle and the latter part of the epidemic. In each time-period or case-group, the age distribution of cases was calculated and the percentage of cases under 10

FIG. 5



years of age (or under 15 years of age in those areas where globulin was administered up to that age) plotted. Figure 5 represents the trends of the 1953 epidemic areas with globulin, earlier epidemics in several of the same areas and epidemics in 1953 without globulin, with such epidemics broken into thirds by equal time intervals. It will be noted that frequent shifts of incidence to older age groups occurred, not only among mass inoculation areas, but also among some of the same counties in earlier epidemic years and among other epidemic areas without mass inoculations in 1953. In fact, there were actually shifts to younger age groups as the epidemic continued among a few counties in each of the three categories compared.

Since case incidence was usually low in the first and third time periods, comparisons were also made, as indicated above, among the three categories of areas utilizing three periods of equal case groups in the several counties. The same lack of significant differences in the character of the age-distribution trends from beginning to end of the epidemics among the three

area categories was noted by this method as well.

An age-shift analysis of 14 good-sized (more than 50 cases) outbreaks of poliomyelitis in Illinois in the period 1948 to 1953 was also made. Shifts to older age group incidence as the epidemic progressed were noted for Champaign and DuPage Counties in 1949, Champaign County in 1951, Coles and Vermilion Counties in 1952 and Kane County in 1953.

It would appear rather that a shift of incidence to older-age groups with progress of the epidemic is one of the natural modes of poliomyelitis outbreaks. Thus, age shift also could not be ascribed as a globulin effect.

### 3. *Modification of Duration of Epidemic*

If gamma globulin had an obviously protective effect, it was felt that the duration of the epidemic for the inoculated age group might be terminated more rapidly with its mass use. Thirteen mass inoculation areas with 25 cases or more receiving gamma globulin and 13 other similarsized epidemic areas, in which mass inoculations were not applied, were compared with respect to attack rates, size of the age group eligible for inoculations and duration of the epidemic. Epidemic duration was measured as the interval of the 10 to 90 percentile range of cases in each outbreak.

Each area, with and without mass inoculations, was plotted according to duration of epidemic and size of population. The scatter was so diffuse for both mass inoculation areas and areas in which no mass inoculations were given, that no consistent differences in duration of the epidemic between the two groups could be demonstrated. Actually, the mean epidemic duration of the 13 mass inoculation counties was 8.5 ( $\pm 2.11$ ) weeks and that of the 13 uninoculated counties was 9.2 ( $\pm 2.62$ ) weeks. The difference of 0.7 weeks was not statistically significant.

### 4. *Differences in Paralytic Attack Rates among Inoculated and Uninoculated Children in the Same Age Groups*

Since not all children eligible for inoculation in a given area availed themselves of the opportunity, a comparison of paralytic attack rates between inoculated and uninoculated children

before, during and after the significant protection period described by Hammon was proposed. Unfortunately, the denominator of uninoculated children was unknown for all the mass inoculation areas. Epidemiological experience within the several areas indicated that uninoculated populations probably varied percentage-wise among the areas — and nothing was known of the relative weights of such items as lack of motivation, accessibility of clinics, educated awareness and other psychosocial factors which may have contributed to differences between the inoculated and uninoculated groups.

Thus, such a comparison was deemed invalid even if the uninoculated denominator had been known because of the obviously disparate size of the groups and factors of disparate composition probably made the uninoculated group a biased selection.

### B. *Modification of Severity of Paralysis*

Hammon had also shown significant modification of severity of paralysis among inoculated children who received gamma globulin the week prior to the onsets of their illness.<sup>1d</sup>

Actually, the statistically significant difference in muscle involvement between the gamma globulin group and the gelatin inoculated group of cases with onsets in the week following mass inoculation was based on but 12 cases in the former and 16 in the latter. Obviously, conclusions based on such small numbers are hazardous.

Nevertheless, the data on muscle evaluations from 5 mass inoculations areas were subjected to extensive analysis in the hope that a marked modifying effect by gamma globulin would be evident in the mildness of paralysis among patients developing poliomyelitis after receiving gamma globulin. In the 5 mass inoculation areas the number of cases among children under 10 years of age, occurring before and after such inoculations, was extensive enough to afford critical analysis of the muscle scores. Physiotherapists, specially trained in a muscle examination technique which was proven to yield highly reproducible results with an error of approximately 3%, provided the 50-70 day muscle examination data. Several comparisons were made, principally between cases without globulin occurring one week prior to mass use and those whose on-

sets occurred in the week and in the month following mass use. Since increasing age apparently predisposes to more severe poliomyelitis among susceptibles and since it was shown that shifts to older age incidence occur as epidemics progress, the age distribution of cases within the 0-9 year group was examined for a similar shift which might influence the final analysis. The Chi-square association test revealed no significant difference in age distribution among cases before and after mass inoculation ( $P = 0.13$ ).

Analysis of the data was carried out utilizing mean muscle scores, percentage of severe cases and percentage of non-paralytic cases. Table 2 presents the distribution of muscle scores in the 5 mass inoculation areas among cases with onsets during specific periods before and after mass inoculation. Although group II cases, i.e., those receiving gamma globulin prior to onset, seemed to have lower mean muscle involvement scores, an analysis of variance test failed to reveal a statistically significant difference between the groups. Attention is also called to the fact that the score of 0.5 to 4.9% was the identical modal

value for both groups and for their subgroups. Differences in percentage of severe cases (i.e., with muscle scores greater than 10%) among the several groups and subgroups were also not statistically significant.

The distribution of cases in the 0-9 year age group in the 5 mass inoculation areas, according to status of paralysis, will be noted in Table 3. It should be noted that status of paralysis is not based upon clinical impressions, but upon precise evaluation of muscle involvement, utilizing the level of 0.49% as the dividing line between paralytic and non-paralytic cases. It would appear from these data that cases occurring 1-7 days after inoculation tended more often to be non-paralytic, a finding which seems to substantiate Hammon's data on severity. However, none of the differences in per cent of non-paralytic cases between the two groups and among the several subgroups are statistically significant. A modifying effect, thus could not be demonstrated.

C. Conclusions on Mass Prophylaxis

On the basis of these findings, the National Advisory Committee summarized its conclusions

TABLE 2  
Distribution of Muscle Scores in Five Mass Inoculation Areas\* Among Cases of Poliomyelitis with Onsets During Specific Periods Before and After Mass Inoculation

Muscle Scores (% Involvement)	Group I				Group II		
	No Gamma Globulin Prior to Onset				Gamma Globulin Prior to Onset		
	Onset in Week Prior to Mass Use	Onset on Day of Mass Use	Onset After Mass Use	Total	1 - 7 Days Before Onset	8 - 31 Days Before Onset	Total
0	6	1		7	7	1	8
0.1 - 0.49			2	2		1	1
0.5 - 4.9	15	3	4	22	11	9	20
5.0 - 9.9	8	1	2	11	4	2	6
10.0 - 14.9	4		2	6	3		3
15.0 - 24.9	4	2		6	3	3	6
25.0 - 34.9	2			2	3		3
35.0 - 44.9	2			2			
45.0 - 54.9							
55.0 - 64.9		1	1	2	1		1
65.0 - 74.9	1			1			
75.0 and over	1			1			
Total	43	8	11	62	32	16	48
Geometric Mean	7.37	7.81	7.36	7.42	5.71	3.76	4.91
(Per cent Involvement)							
Per cent of Severe** Cases	32.6	37.5	27.3	32.3	31.3	18.8	27.1

Analysis of Variance Table\*\*\*

Source of Variation	d.f.	S.S.	M.S.	F
Between Groups	1	.722	.722	2.80
Within Groups	90	23.191	.258	
Total	91	23.913		

F Test Significance: F = 2.80  
P = .10

\*Caldwell, N. C.; Catawba, N. C.; Chemung, N. Y.; Macon, Ill.; Steuben, N.Y. Counties.

\*\*Muscle Scores of 10 per cent or more.

\*\*\*Based on cases having muscle scores of 0.5 per cent or greater. Analysis of Variance Test for difference between geometric means of groups.

TABLE 3  
Distribution of Paralytic and Nonparalytic Cases in Five Mass Inoculation Areas\*  
with Onsets During Specific Periods Before and After Mass Inoculation

Status of Paralysis	Group I No Gamma Globulin Prior to Onset				Group II Gamma Globulin Prior to Onset		
	Onset in Week Prior to Mass Use	Onset on Day of Mass Use	Onset After Mass Use	Total	1 - 7 Days Before Onset	8 - 31 Days Before Onset	Total
Paralytic Cases	37	7	9	53	25	14	39
Nonparalytic Cases**	6	1	2	9	7	2	9
Total	43	8	11	62	32	16	48
Per cent Nonparalytic	14.0	12.5	18.2	14.5	21.9	12.5	18.8

\*Caldwell County, N. C.; Catawba County, N. C.; Macon County, Ill.; Steuben County, N. Y.; Chemung County, N. Y.

\*\*0.49 per cent involvement or below.

as follows: "The mass injection of gamma globulin, carried out on a large scale in 1953 in the United States as a method to prevent paralysis in poliomyelitis infection, was done as a public health measure in response to a widespread demand and not on an experimental basis. As such, attempts to draw conclusions regarding its efficacy have not been easy and, in many instances, have been impossible. In any event, the methods of analysis of carefully compiled and extensive data on the use of gamma globulin in these epidemic areas, where it might have been expected to be effective, did not yield statistically measurable results. Therefore, its preventive effect in community prophylaxis, as practiced during 1953, has not been demonstrated. Also, no modification of the severity of paralysis by gamma globulin was shown. Nevertheless, the Committee cannot say that the use of gamma

globulin by mass inoculation produced no effect."<sup>3</sup>

### III. *Evaluation of Household Contact Prophylaxis*

As indicated in the Introduction, gamma globulin prophylaxis for household contacts to diagnosed cases of poliomyelitis was applied in the hope that a certain number of cases subsequent to the index case in multiple-case households might be prevented and many more might have distinct modification of severity of the disease. In collected data from several sources (Table 4), it was noted that by the time the initial case in a multiple-case household reached medical care and a diagnosis was established (4-5 days), fully 60% of the subsequent cases had already had their onset. Furthermore, in the second time-interval group (6-12 days) representing another 30% of

TABLE 4  
Interval Between Onsets of Index and Subsequent Cases of Poliomyelitis in Multiple Case  
Households Collated from Various Series by Dr. William Clark

Interval in Days	Number and Per cent of Subsequent Cases													
	1		2		3		4		5		6		7	
	Sweden (1905)		New York City (1916)		Collected Series* (1910 - 1924)		Los Angeles (1943)		Minnesota (1946)		New York State (1950)		Utah-Iowa (1951 - 1952)	
	No.	%	No.	%	No.	%	No.	%	No.	%	No.	%	No.	%
0 - 5	81	63.8	285	72.1	77	55.0	22	57.9	122	62.2	79	57.2	19	59.3
6 - 12	34	26.8	92	23.3	44	31.4	14	36.8	60	30.6	35	25.4	11	34.4
13 - 30	12	9.4	18	4.6	19	13.6	2	5.3	14	7.2	24	17.4	2	6.3
Total	127	100.0	395	100.0	140	100.0	38	100.0	196	100.0	138	100.0	32	100.0

\*To 25 day interval only.

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TABLE 5  
Distribution of Severity of Paralysis Based on the 50-70 Day Muscle Examination and Distribution of Deaths Among the 415 Cases According to Gamma Globulin Group

Per Cent Muscle Involvement	No Gamma Globulin	Days Before Onset			Day of or After Onset			Total
		6+	3-5	1-2	Same Day	1-2	3-8	
0.5 - 1.4	18	5	7	3	4	2	3	42
1.5 - 2.4	26	7	3	10	6	2	2	56
2.5 - 3.4	18	6	5	5	2	2	2	40
3.5 - 4.4	22	4	6	7	3		1	43
4.5 - 5.4	15	2	4	3	3	4	1	32
5.5 - 6.4	10	5	3	3	3	2	2	28
6.5 - 7.4	7	4	2	3	3	3		22
7.5 - 8.4	5	1	3	3	2			14
8.5 - 9.4	4	1		1	1	1		8
9.5 - 24.4	26	10	13	10	4	3	3	69
24.5 - 49.4	17	1	6	3	2	1	1	31
49.5 - 99.9	16	2	3	4	4	1		30
Total	184	48	55	55	37	21	15	415
Geometric Mean	6.3	5.1	7.0	6.0	6.1	5.9	4.2	6.1
Per cent Severe Cases*	32.1	27.1	40.0	30.1	27.0	23.8	26.7	31.3
Number of Deaths	9	2	2	3		2		18

\*Cases having 9.5 per cent or greater involvement.

the subsequent cases, only modification of severity could be expected and finally in only 10%, with onsets prolonged beyond the second week, could a preventive effect be anticipated. Hammon<sup>1d</sup> as well as Clark<sup>4</sup>, however, had indicated that the morbidity rate among this last group of secondary cases in families was as high or higher than that expected among children in the general population even in very severe epidemics and Hammon had even gone so far as to say that "in families of diagnosed cases, gamma globulin should prevent more disease and disability per thousand units employed than if given on a mass basis in areas where epidemics occur."<sup>1d</sup>

Since rigid experimental design with injected controls could not be applied for study in 1953, a definitive comparison of secondary attack rates among familial contacts with and without gamma globulin could not be made. It was hoped that the extensive study of multiple-case households might, however, yield some evidence of prevention. Greater reliability was thus placed upon an analysis of modification of severity of paralysis among subsequent cases and, since the practical value of contact prophylaxis depends largely upon the existence of a modifying effect of gamma globulin, this study was considered extremely worthwhile.

Forty-one states and 4 metropolitan areas participated in this phase of the study and represented 90% of the national population. Suitable records on 830 multiple-case households representing 1,828 reported cases were analyzed

by the National Evaluation Center at Atlanta. Three approaches to evaluation were possible: 1) Modification of severity of paralysis among subsequent cases; 2) The proportion of non-paralytic cases among subsequent cases with and without gamma globulin prior to onset; and 3) Deviation from the pattern of familial aggregation of cases.

#### A. Modification of Severity of Paralysis

Although a direct association was found between the clinical status of index and subsequent cases in the same families (i.e., cases developing subsequent to paralytic index cases were more frequently paralytic or fatal whereas cases developing subsequent to non-paralytic cases were more frequently non-paralytic), it was not deemed valid to compare severity between index and subsequent cases for the reason that index cases would tend to be more severe and attention may have been called to mild cases in the family which might otherwise have been missed. Comparisons were thus limited to subsequent cases.

Records on 749 multiple-case households constituting 1,654 individual patients were found suitable for analysis. 749 were index cases, 8 were prior cases, 80 were concomitant or co-index cases and 817 were truly subsequent cases. Among the subsequent cases, fortunately for the study, 50% received no globulin, 16% received it on or after onset and 34% received it before onset, thus permitting intra-group comparisons of severity. Principal reasons for such a large proportion not receiving globulin include the

time interval required for recognition of the index case and the large numbers of cases developing with or shortly after the index case.

Before intra-group comparisons could be made, tests for homogeneity of the group had to be made. Five per cent of the cases were non-white and were excluded since they came from a different socio-economic segment of the population. Since approximately 4% of the subsequent cases were under one year of age and presented difficulties in proper muscle evaluation, these were also excluded. Since in only a few areas was globulin made available to contacts 30 years of age or older (other than pregnant women), a serious bias would have been introduced if older cases with their notoriously higher case-fatality rates and obviously receiving no gamma globulin had been included. By such exclusions, 666 subsequent cases remained. In order that some cases diagnosed as non-paralytic which might not have been polio might not affect the comparisons, only paralytic cases developing subsequently to paralytic index cases were finally subjected to detailed analysis. For reasons which time does not permit to enumerate, a muscle score of 0.5% involvement or higher at the 50-70 day examination was chosen to define a paralytic case. Thus, 415 cases remained for analysis.

This homogeneous group was then distributed according to severity of paralysis and administration of gamma globulin. This is presented in Table 5. Fully 184 cases or 44% of this group received no globulin; 73 or 18% received globulin on the day of or after onset; and 158 or 38% received globulin at varying intervals before onset. The geometric mean involvement of the 7 sub-

groups will be noted to vary from 4.2% for cases receiving globulin rather long after onset to 7.0% among cases receiving globulin 3-5 days before onset. No trend is apparent and no significant difference exists among any of the subgroups.

Severe cases, representing muscle involvement of 9.5% or greater, likewise were distributed in almost equal proportions among the 7 subgroups without trend or statistically significant differences. Similarly, there is no suggestion of differences in case-fatality rates among the no-globulin and late-globulin subgroups (4.1%) on the one hand and the globulin subgroups (4.2%) on the other.

This crude analysis, however, fails to recognize known differences in the data. For example, although the bulk of the subsequent cases were under 15 years of the age according to the present classical pattern of age distribution (Table 6), a significant number of cases in the age group 15-29 years with anticipated and demonstrated greater muscle involvement are present. (The greater number of these are females and mothers of index cases, probably indicating greater intimacy of exposure than for males of corresponding age.) Furthermore, the intervals between onset of index and subsequent cases vary considerably, but within the pattern of familial aggregation noted above. Since some observations in the laboratory and field suggest that subsequent cases might become milder as this interval increases and may represent individuals with longer incubation periods, this variable must also be considered.

Thus, a multiple factor analysis of variance to measure these contributing and unequal varia-

TABLE 6  
Distribution of the 415 Subsequent Cases by Age, Interval between Onset of Index and Subsequent Case, and Administration of Gamma Globulin

Age (Years)	Index — Subsequent Onset Interval (Days)	Administration of Gamma Globulin								
		Days Before Onset					Days After Onset			
		None	6+	3-5	1-2	0	1-2	3+	Total	
1-4	1-3	19	—	—	6	9	2	1	37	
	4-7	15	—	10	10	2	1	1	39	
	8+	2	8	7	1	1	—	1	20	
5-14	1-3	52	1	2	8	8	5	4	80	
	4-7	33	2	12	17	9	3	2	78	
	8+	18	24	17	6	4	—	—	69	
15-29	1-3	12	—	2	—	1	2	3	20	
	4-7	20	3	—	5	1	6	2	37	
	8+	13	10	5	2	2	2	1	35	
Total		184	48	55	55	37	21	15	415	

TABLE 7  
Calculated Estimates of the Individual Age, Interval and Gamma Globulin Components, and their Standard Errors

Components			Deviation from Mean of Group	Standard Error of Deviation
Gamma Globulin				
Before Onset	None	g <sub>1</sub>	0.046	0.046
	6+ days	g <sub>2</sub>	-0.064	0.078
	3-5 days	g <sub>3</sub>	0.104	0.069
	1-2 days	g <sub>4</sub>	0.045	0.067
	0 days	g <sub>5</sub>	0.052	0.078
After Onset	1-2 days	g <sub>6</sub>	-0.022	0.100
	3+ days	g <sub>7</sub>	-0.161	0.115
Age	1-4 years	a <sub>1</sub>	-0.050	0.041
	5-14 years	a <sub>2</sub>	-0.059	0.033
	15-29 years	a <sub>3</sub>	0.109	0.042
Index-Subsequent Onset Interval	1-3 days	t <sub>1</sub>	0.002	0.039
	4-7 days	t <sub>2</sub>	-0.017	0.035
	8+ days	t <sub>3</sub>	0.015	0.043

TABLE 8  
Analysis of Variance for Gamma Globulin, Age, and Interval Components

Source of Sum of Squares	Degrees of Freedom	Sum of Squares	Mean Square ( $\frac{S.S.}{D.F.}$ )	Ratio of Mean Square to Residual Mean Square (F)	P
"Base-line" severity (u) .....	1	255.1854			
Gamma Globulin components .....	6	1.3472	0.2245	0.897	0.50 < P < 0.70
Age Components .....	2	1.8070	0.9035	3.610	0.025 < P < 0.05
Interval Components .....	2	0.0590	0.0295	0.118	0.10 < P < 0.20
Residual .....	404	101.1228	0.2503		
Total .....	415	359.5214			

tions and to normalize their actions had to be employed. The components of these variables are listed in Table 7 and include interval of onset to globulin administration, age and interval between onsets of index and subsequent cases. An analysis of variance following normalization or "elimination" of certain weighting influences reveals (Table 8) that only age played a part in any differences in muscle involvement among the subgroups. The interval of gamma globulin administration had no statistically significant effect nor did the interval between onsets of index and subsequent cases. Individual tests of significance between the group which did not receive gamma globulin and each of the 6 groups which did (Table 9) failed to reveal any significant differences.

#### B. Proportion of Non-Paralytic Cases

An analysis of clinical type of subsequent cases utilizing 0.5% muscle involvement at the 50-70 day interval as the lower limit for paralysis is presented in Table 10. No significant differences can be found.

#### C. Deviation from Pattern of Familial Aggregation

In Table 11 the 415 subsequent cases are distributed according to interval since onset of index case and to it are added 45 co-index cases to make the data comparable to the collected data of Table 4. It can be seen that the pattern of aggregation of cases within families by interval

since onset of the index case is virtually identical to the normally observed experience.

#### D. Conclusions on Household Contact Prophylaxis

The National Advisory Committee concluded that "the data on the efficacy of gamma globulin in household contacts that have been accumulated in 1953 are considered to be adequate for reliable conclusions. They indicate that with the preparations employed and in the dosages used, the administration of gamma globulin to familial associates of patients with poliomyelitis had no significant influence on:

1. The severity of paralysis developing in subsequent cases;
2. The proportion of non-paralytic poliomyelitis among the subsequent cases who received gamma globulin before onset; and
3. The classical pattern of familial aggregation of cases in the country at large."

### GENERAL DISCUSSION AND CONCLUSIONS

It is obvious that an incisive statement regarding the efficacy of gamma globulin in mass application could not have been made without the presence of simultaneously inoculated control groups among the same populations, the scientific method being what it is; but it is equally obvious that the use of gamma globulin by mass inoculation in 1953 failed to produce the dramatic and marked effects anticipated from Hammon's data when practical application on a wide national

TABLE 9  
Individual Tests of Significance of the Gamma Globulin Components

Comparison of group receiving no gamma globulin with groups receiving gamma globulin:		Difference Between Components $g_1 - g_1$	Standard Error of Difference	Ratio of Difference to Standard Error	P
6 or more days before onset .....	( $g_1 - g_2$ )	0.1103	0.0928	1.19	0.23
3-5 days before onset .....	( $g_1 - g_3$ )	-0.0578	0.0824	-0.70	0.48
1-2 days before onset .....	( $g_1 - g_4$ )	0.0009	0.0785	0.01	0.99
On day of onset .....	( $g_1 - g_5$ )	-0.0062	0.0907	-0.07	0.94
1-2 days after onset .....	( $g_1 - g_6$ )	0.0679	0.1163	0.58	0.56
3 or more days after onset .....	( $g_1 - g_7$ )	0.2073	0.1349	1.54	0.12

TABLE 10  
Proportion of Paralytic\* and Non-Paralytic\* Subsequent Cases of Poliomyelitis, 1-29 Years of Age, in Multiple Case Households, According to Administration of Gamma Globulin. United States, 1953.

Type	Total Number Subsequent Cases	No GG		GG Before Onset		GG on or After Onset	
		No.	%	No.	%	No.	%
Paralytic .....	490	226	76.1	179	71.6	85	71.4
Non-paralytic .....	176	71	23.9	71	28.4	34	28.6
Total .....	666	297	100.0	250	100.0	119	100.0

\*Based on 50-70 day Muscle Evaluation with 0.5% involvement as level of division.

scale with a limited supply of gamma globulin was attempted. It was these anticipated marked effects which the evaluation studies of mass prophylaxis counted on to demonstrate efficacy without rigid controls. A method of prophylaxis, based upon a product of such short supply that its use must be selective and selection of areas, furthermore, based on exceedingly faulty prediction techniques, is probably doomed to failure from the start. Even among the areas of Hammon's study, the Harris County, Texas epidemic was cited by him as a type of outbreak in which use of gamma globulin was unreasonable because of its lower rates and prolonged epidemic pattern<sup>5</sup>.

Futhermore, it is rather strange that a biologic which is supposed to prevent cases of disease by conferring passive immunity failed even to show evidence of modification with the relatively more valid data which were available. Even attempts at prevention of measles with full doses of globulin given quite early in the incubation period fails to prevent in every instance and such failures are distributed disproportionately among modified and full-blown cases in that order.

The evidence against household contact prophylaxis is much more clear, however, and the failure of gamma globulin here may be attributed to universal familial infection concurrently with the index case. Nevertheless, modification should have been expected to occur among some of the familial recipients of gamma globulin, especially among those with prolonged incubation periods, unless protection or amelioration by passive antibody is utterly impossible once the virus has gained access to the body even though the central nervous system has not yet been invaded. The failure of gamma globulin in household contacts dictates that none shall be used in this fash-

ion. In Illinois, as elsewhere, gamma globulin will not be provided for such use in 1954.

Notwithstanding the impractical considerations of mass application of gamma globulin with its criteria of selectivity which are virtually unpredictable and quite limited even if we are to accept Hammon's indications for use, gamma globulin supplies have once more in 1954 been earmarked for what has been termed "group" prophylaxis. No one has been able to define adequately a group beyond household associates who are no longer eligible, for there are many good epidemiologic reasons against most applications. If one names classroom contacts as a

TABLE 11  
The Distribution of Intervals Between Onset of the Index and the 415 Subsequent Cases According to Gamma Globulin Group

Interval in Days	No Gamma Globulin	Days Before Onset			Day of or After Onset			Total
		6+	3-5	1-2	Same Day	1-2	3-8	
1	40	—	—	1	1	3	6	51
2	22	—	1	4	9	3	2	41
3	21	1	3	9	8	3	—	45
4	24	—	1	11	5	3	4	48
5	18	1	6	8	5	3	—	41
6	15	1	7	9	1	—	—	33
7	11	3	8	4	1	4	1	32
8	9	2	10	—	4	1	—	26
9	2	7	4	4	1	1	1	20
10	5	3	5	3	1	—	—	17
11	2	9	6	2	—	—	1	20
12	1	2	1	—	1	—	—	5
13-30	11	16	3	—	—	—	—	30
31-43	3	3	—	—	—	—	—	6
Total	184	48	55	55	37	21	15	415

Summary		
Interval in Days	Number of Cases	Per Cent
0-5	271*	59.7*
6-12	153	33.7
13-30	30	6.6
Total	454	100.0

\*Includes 45 co-index cases selected from the total of 80 co-index cases of the total series on the same basis as the 415 cases were selected from the 817 of the total series.

group, we are faced with the fact that rarely, if ever, do second cases in the same classroom occur. If one considers summer camps, we must recognize that rarely does more than one case occur and if multiple cases are experienced, these occur within the first week from onset of the index case. In both we are probably dealing with exposure of the family type. A suggestion might be inoculation of children prior to their departure for camp. If we turn to institutions, experience likewise reminds us of the extremely low attack rates and the serologic evidence of high immunity among such groups.

If we turn to housing projects or neighborhoods in cities, we again are faced with methods of prediction which are grossly inadequate. If a case or two occurs in a rural village within one week, this may be the only incidence for the season even though it may be portentous.

These are but a few examples of the difficulties facing us today in the application of gamma globulin in the prophylaxis of poliomyelitis despite all evidence of its impracticality and highly questionable value.

The Illinois Poliomyelitis Technical Advisory Committee has recommended to the Illinois Department of Public Health that gamma globulin be issued for *group* inoculations at the discretion of the local full-time health officers and the local

medical societies. This will be the policy of the Department in 1954. None will be available for household contact use.

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Careful clinical evaluation of each person found to have suspected tuberculosis on a miniature film is of great importance in predicting the likelihood of future disability or death. Wendell R. Ames, M.D., and Miller H. Schuck, M.D., Am. Rev. Tuberc., July, 1953.

# The Present Status of Vaccines for the Prophylaxis of Poliomyelitis

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In considering the present status of our knowledge about the prophylaxis of infantile paralysis it is well to remember that today's promising approaches to the development of an effective vaccine are all based on earlier investigations carried out in the past by scores of careful workers in this field. So rapid has been the progress in the last few years and so pregnant with hope for the future, that it is easy to overlook the basic principles and fundamental concepts upon which our present ideas of the immunogenesis of this disease have been built.

The discovery in 1909 by Landsteiner and Popper<sup>1</sup> of the susceptibility of monkeys to poliomyelitis was followed the next year by reports from Flexner and Lewis<sup>2</sup> as well as from Römer and Joseph<sup>3</sup> that active immunization of primates was possible. They also observed that virus, when mixed with sera from monkeys protected by such immunization, produced no ill effect when injected into a normal monkey; the blood of the convalescent animal therefore contained antibodies that had inactivated or neutralized the infecting agent.

In the early experimental work, monkeys were infected and challenged by inoculations given directly into the central nervous system. It was learned later that infection also could be induced by intranasal instillation of the virus; invasion took place via the olfactory lobes to the brain. While this concept of the pathogenesis of the experimental disease appears to be essentially correct for rhesus monkeys infected by intranasal instillation of the virus, more recent findings suggest that the mechanism in man may be quite different. It now seems probable that

poliomyelitis virus gains entrance to the human body through the mouth and, after a limited alimentary phase, it may reach the tissues of the central nervous system either via the blood stream or by migration along nerve fibers. Until the last decade, no method was known for producing in animals a pattern of infection corresponding to that observed in man. In 1941, however, Howe and Bodian<sup>4</sup> observed that chimpanzees could be infected readily by oral inoculation of the virus.

For about twenty years after the initial discovery of the susceptibility of rhesus monkeys to poliomyelitis, puzzling inconsistencies were encountered in the immune response of certain experimental animals and human beings after exposure to the virus. As early as 1931 in Australia, Burnet and Macnamara<sup>5</sup> noticed that there appeared to be immunological differences between individual strains. By 1949 two independent groups of workers in this country<sup>6,7</sup> had reached the conclusion that there must be at least three basic, immunologically distinct types of these viruses. A careful and systematic study of this problem was begun in 1948 and completed five years later. It indicated that poliomyelitis viruses can be separated into three broad antigenic groups or types.<sup>8,9</sup> Among 196 strains classified by cross immunity tests in monkeys, 161, or 82 per cent were found to belong to Type 1; 20, or 10 per cent to Type 2; and 15, or 8 per cent to Type 3.

Each type is capable of causing paralytic polio in the human being and of inducing a type-specific immunity. A patient who has recovered from an attack with one type remains susceptible to infection with the other two types. However, only a few individuals develop paralysis as a result of successive attacks with more than one type of virus.

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The Brunhilde strain, the prototype of Type 1 bears the name of a chimpanzee that became severely paralyzed eight days after intranasal inoculation of a suspension of stools from seven paralytic patients in Baltimore. The prototype strain of Type 2 was isolated in 1938 from a fatal human case in Lansing, Michigan, and was given the name of that city. The Leon strain, the prototype of Type 3, was obtained from the brain and spinal cord of an 11 year old boy who died in Los Angeles, California, in 1937. The discovery that there are three different types of polio virus is of fundamental importance because a vaccine, to be effective, must provide immunity to all three types.

Early attempts to vaccinate experimental animals were made with virus-infected tissues derived from the central nervous system of monkeys or mice, but the danger of allergic encephalitis from the use of such preparations is a real one. An important advance occurred, when Enders, Weller, and Bobbins<sup>10,11</sup> found that poliomyelitis viruses could be grown on small pieces of nonnervous tissue, of human or animal origin, proliferating in glass containers. This discovery was soon confirmed at several other laboratories and it is now known that poliomyelitis virus will multiply on cells growing out from small fragments of human tissues such as embryonic skin-muscle, adrenal, heart, intestine, kidney, prepuce, spleen, testis, thyroid, tonsil, and uterus; and also on monkey intestine, kidney, lung, muscle, and testis.

In the initial experiments of Enders and his colleagues, fragments of living tissue were suspended in a mixture of balanced salt solution and ox serum ultrafiltrate. A synthetic medium, known as Mixture No. 199, developed in Toronto, Canada, by Morgan, Morton, and Parker<sup>12</sup> is widely used also. This complex mixture contains more than 60 ingredients.

Growth of living cells in tissue cultures proceeds satisfactorily in a variety of glass containers. These include test tubes, small flasks of various shapes and sizes and the big rectangular Povitsky (diphtheria) toxin bottles in each of which virus can be propagated in amounts as large as 750 cc. In some laboratories, inoculated tubes are placed in a roller mechanism which causes the nutrient fluid to wash slowly over the living cells embedded in a plasma clot.

Recently it has been found that for certain types of work, stationary tubes are equally satisfactory, and the rolling mechanism does not appear to be essential.

In the tissue cultures themselves cellular growth takes place rapidly, new cells budding out in all directions from the fragments of living tissue. These new cells spread over the inner surface of the container like ivy climbing up a wall. When poliomyelitis virus is added, cytopathic changes appear within a few days and many of the cells die. If antibodies derived from a convalescent patient originally infected with that same type of poliomyelitis virus are added, those living cells do not die. Characteristic cytopathic changes resulting from infection of living cells with each of the three known types of poliomyelitis virus are readily seen in a microscope.

Not only are tissue culture procedures now employed for titrations of virus and antibody levels, but methods for the quantity production of poliomyelitis viruses in cultures of monkey kidney tissue have been developed. Pioneers in this field were Farrell, Wood, Franklin, Shimada, MacMorine, and Rhodes.<sup>13</sup> They showed that the Mahoney strain, a Type 1 virus, could be cultivated in large rotating bottles containing rhesus monkey kidney epithelium and synthetic nutrient medium No. 199. Virus titers greater than  $10^{-5}$  were obtained in volumes of fluid as large as 500 cc. or even 2000 cc. They secured similar titers with strains of Types 1 and 2 grown in half liter amounts in Povitsky or diphtheria, toxin bottles following mechanical rocking for three days or more.

With this introduction to some of the basic discoveries which led to the development of possible methods of immunization against poliomyelitis, it will be appropriate to proceed with a discussion of the present state of our knowledge concerning possible vaccines for this disease. There are a number of different ways in which a satisfactory vaccine might be prepared. These include inactivation of the virus by chemicals or other agents, serial passage of the virus through some unnatural host or under unusual cultural conditions, or administration of adequate amounts of immune serum

followed by virus. Since rapid progress has occurred recently in the development of at least one type of inactivated vaccine, it seems appropriate to discuss that approach first.

A. *Inactivated Vaccines.* Boyd<sup>14</sup> has called attention to the fact that it is extremely difficult to achieve immunity to paralytic poliomyelitis in experimental animals so long as they were challenged intracerebrally or intranasally. Such a high degree of immunity does not appear to be necessary however, to protect animals against oral inoculation of the virus, which is now considered to be the way by which human beings become infected. Valuable data on this aspect have been assembled following the discovery that in chimpanzees and cynomolgus monkeys, infection can occur by the mouth. Indeed there is good evidence that certain inactivated vaccines may be able to stimulate the production of adequate levels of antibodies in such experimental animals.

The capacities of a number of different chemical compounds to inactivate poliomyelitis virus, without destroying its antigenicity, have been studied in the past, in animals only, while other materials received limited trials on groups of human volunteers. Those agents included aluminum hydroxide, chloroform, formalin, glycerol, nitrogen mustard, phenol, potassium chlorate, sodium ricinoleate, and tannic acid.

Brief mention should be made of the attempts at human immunization carried out by Brodie and Park<sup>15</sup> with a formalin inactivated preparation and by Kolmer<sup>16</sup> with ricinoleated vaccine. Those trials were discontinued because the preparations employed were found unsafe for human use. In addition, since they were made prior to the discovery that there are three immunogenically distinct types of poliomyelitis virus, no further reference will be made at this time to the experimental vaccines developed by Kolmer and Brodie.

In 1948 Morgan<sup>17</sup> demonstrated that a formaldehyde-treated suspension of central nervous system tissue from monkeys containing a Type 2 strain of poliomyelitis virus, after a rigorous schedule of immunization, did induce the formation of appreciable levels of antibody to that strain. After much additional experimental work with other types of virus in rhesus monkeys Howe<sup>18</sup> reported in 1952, that six children

and 10 chimpanzees developed demonstrable neutralizing antibodies following the injection of small quantities of clarified monkey cord suspensions containing formalin-inactivated poliomyelitis virus of all three types. With the rapid development of tissue culture techniques, however, further investigations of such monkey cord suspensions have been abandoned in favor of tissue culture fluid vaccines.

In this particular field two recent reports by Salk<sup>19,20</sup> indicate significant progress. For his vaccine he selected the Mahoney, MEF<sub>1</sub> and Saukett strains as representatives of Types 1, 2 and 3 respectively. All are propagated in synthetic medium No. 199 of Morgan, Morton, and Parker. Although virus was originally grown by Salk in monkey testis, more recently he has been growing it entirely on monkey kidney tissues. He points out that one of the advantages of the development of tissue culture methods for the propagation of poliomyelitis virus is that preparations are obtained that are relatively free from extraneous antigens. Greater proficiency in methods of virus cultivation also have increased the available antigenic mass. Salk has estimated that more than 4,000 monkeys have been utilized in testing the safety and antigenicity of his vaccine.

Initially inactivation with formalin was carried out at the temperature of melting ice. More recently, Salk has reported better results by inactivating filtered infectious tissue culture fluids, adjusted to a pH of 7.0, at a temperature of 36-37° C. Under those conditions, virus is exposed to a 1 to 4,000 solution of formaldehyde for several days longer than the minimum time required to destroy its activity as detectable by titration in tissue culture tubes. Absence of infectivity of the vaccine is verified by intracerebral inoculations into rhesus monkeys, intramuscular injections of cynomolgus, and by inoculation of numerous cultures of monkey kidney tissues.

Immunogenic potency of this vaccine was originally increased by administering it with a mineral oil adjuvant. In view of a report by Philip *et al.*,<sup>21</sup> of the development of sterile abscesses requiring prolonged drainage at the site of injections of certain adjuvant vaccines for influenza, it has seemed prudent to avoid the use of adjuvants in the poliomyelitis vac-

cine presently under extensive trial. In certain preliminary studies a total of 372 children living in Allegheny County, Pennsylvania, were inoculated with adjuvant vaccines; 103 received a single dose of adjuvant vaccine and 105 two doses. Immunization with an adjuvant vaccine, followed by an aqueous vaccine, was administered to 133 other volunteers while 30 were given aqueous vaccine initially, followed by adjuvant vaccine later. No untoward effects were observed in this group either at the site of inoculation or systemically.

The immunogenic potency of the aqueous vaccines was raised by increasing the antigenic mass as a result of improved methods of tissue culture cultivation. In addition, advantage was taken of the booster phenomenon by giving three successive inoculations, the third after an interval of four weeks. Antibody levels induced by such vaccinations compared favorably with those that develop following natural infection with the disease.

Salk has reported<sup>22</sup> that children and adults, who have no antibody to any of the poliomyelitis viruses, can produce as a result of such vaccinations antibodies to all three types of the virus. The extraordinary height to which antibody levels are raised in persons who had some antibody at the time of initial vaccination is impressive.

Observations over a period of seven months are available from one group of 11 youngsters who originally had had no antibodies to any of the three types of virus<sup>23</sup>. These children varied in age from 3 to 12 years. Initially, they received three doses of 1cc. each of aqueous vaccine on three successive weeks. Seven months later they were bled. All had antibodies to Type 1 virus in titers varying from 4 to 64. Nine of the 11 children also had similar levels of protective substances against Type 2 virus and 10 against Type 3. A booster injection, the fourth actual inoculation of poliomyelitis vaccine was given at this time, and the children were all bled again 12 days later; antibody levels had risen to titers of from 128 to 4,096. Even the two youngsters who had no demonstrable antibodies to Type 2 virus and the child with no demonstrable antibodies to Type 3 showed similar responses to the booster inoculation.

Some information has been secured on the rapidity with which the immune response takes

place. Among children who had never been exposed to the virus of poliomyelitis, antibodies made their appearance between six and nine days after the first inoculation of 1 cc. of aqueous poliomyelitis vaccine. Individuals already immune to one type responded more rapidly.

Prior to the commencement of the large scale field trials a total of 9,012 individuals in Allegheny County, Pennsylvania, had been inoculated with aqueous poliomyelitis vaccines of the Salk type. Of these, 4,948 were injected with inactivated vaccines prepared in Dr. Salk's laboratory and 4,064 had received commercially prepared products. Among the latter, 3,097 had been under observation for more than 21 days following their first inoculation of vaccine. No reactions were encountered with the single exception of transient urticaria in a child allergic to penicillin. Many children sensitive to a number of other allergens have been vaccinated without discernible ill effects.

Because of the fact that virus for vaccine is propagated in cultures of monkey kidney tissue, some have wondered whether or not immunization with such vaccines might have some damaging effect upon human kidneys. This question has been the subject of careful study in a variety of ways and Salk knows of no indications thus far of any harmful effects upon the kidney, either in experimental animals or in man.

Blood sera collected by Salk from a hundred children before and after inoculation on a variety of different vaccine schedules, have been tested for the presence of antibodies to monkey kidney protein. Some of those youngsters had received one or two injections of adjuvant vaccines, others an adjuvant vaccine followed by an aqueous vaccine or vice versa, and the remainder were immunized with aqueous vaccines given at various intervals of time. Complement fixation tests were used to indicate the possible presence of antibodies to monkey kidney tissues. The antigen employed was an aqueous extract of monkey kidney homogenate. With only one of these sera was any complement fixation demonstrable and that was a specimen taken on the second bleeding from a child who had received two inoculations of an adjuvant vaccine. This particular serum obtained after the second or booster injection showed only a low titer [1 to 5], of antibodies to monkey kidney tissue.

It may be helpful to mention in this connection that the specifications and minimal requirements for the aqueous poliomyelitis vaccine as developed by Salk include the following stipulations concerning nitrogen content. "The batch of filtered tissue culture fluid with an infectious titer of  $10^{-5}$  or greater will be considered suitable for further processing if it contains less than 0.35 mgm/ml. of total Nitrogen, 0.20 mgm/ml. of amino Nitrogen and 0.02 mgm/ml. of protein Nitrogen. It may be noted that synthetic nutrient fluid No. 199 itself, without kidney cells or virus, contains approximately 0.25 mgm/ml. of total Nitrogen and 0.12 mgm/ml. of amino Nitrogen."

Questions also have been raised as to the possibility that isosensitization to the Rh factor might result from the use of this vaccine. This matter was discussed on a number of occasions with Dr. Alexander S. Wiener. He has pointed out that if human subjects, both Rh positive and Rh negative are immunized with red cells from rhesus monkeys, while they may produce antibodies specific for rhesus red cells, it is hardly likely that such antibodies would cross-react specifically with other human red cells, whether Rh positive or Rh negative. He concluded, therefore, that Rh — Hr sensitization would not result from the use of the Salk vaccine. In addition he called attention to the fact that kidney tissue is known to be a poor antigen.

Specifications and minimum requirements for the commercial production of the aqueous poliomyelitis vaccine developed by Salk have been adopted by the Advisory Committee on Active Immunization of the National Foundation for Infantile Paralysis. A series of safety tests are stipulated that must be completed before each lot of aqueous vaccine is released. The tests are carried out at Dr. Salk's laboratory, at the laboratory of the biological house which is responsible for manufacturing that lot of vaccine, and at the National Institute of Health. At each laboratory this series of tests includes the intrathalamic injection of 12 rhesus monkeys, 0.5 cc. of material being given intracerebrally on each side, and the intramuscular inoculation of six cynomolgus with 10 cc. of vaccine each. Histologic studies are made on any animals that die as well as on all survivors on the 28th day after inoculation.

A further check on inactivation of the virus requires the inoculation of 40 monkey kidney cell tissue culture tubes followed by blind tissue culture passages, at each of the three institutions specified above. This necessitates the inoculation of a total of 195 tissue culture tubes altogether. Each tube is observed for cytopathogenic changes on the 3rd and 4th day, the 7th day, the 10th or 11th day, and on the 14th day. In addition each batch of polyvalent vaccine is tested for sterility and for the presence of B virus, lymphocytic choriomeningitis virus, and *Mycobacterium tuberculosis*. Two rabbits are inoculated on the scarified cornea and intracerebrally, 10 mice intracerebrally, 10 embryonated eggs into the yolk sac, and 4 guinea pigs intraperitoneally and intracerebrally. Prior to release of each lot of bulk vaccine immunogenic potency tests are carried out in five monkeys. In addition, each lot of vaccine is tested by Salk himself for its capacity to elicit antibodies in human beings.

Because the actual incidence of paralytic poliomyelitis in any given area is low, many thousands of children will have to be inoculated to determine whether or not the vaccine is effective in preventing paralysis when the virus is encountered under natural conditions. That is the purpose of the extensive field trials presently under way.

Investigations with another type of inactivated poliomyelitis vaccine have been reported recently by Milzer *et al.*<sup>24</sup> They used both adjuvant and aqueous trivalent vaccines which were inactivated by ultraviolet light. Only minimal reactions were encountered by them among 30 human volunteers inoculated. They stated also that they have been unable to detect the presence of anti-monkey kidney precipitins in the sera of several subjects who had developed high antibody titers against all three virus types.

#### B. Live Virus Vaccines.

Serial passage of poliomyelitis virus through unnatural hosts is another promising approach to this problem. For instance, a group of workers at the Lederle Laboratories<sup>25</sup> reported that the MEF<sub>1</sub> strain of human poliomyelitis virus, a Type 2 strain, had become adapted to propagation in developing chick embryos, following 119 serial passages in baby hamsters. Monkeys and chimpanzees that received intramuscular or oral

inoculations with this strain were reported to be immune to subsequent challenge with homologous virus. Infectivity tests of this strain by intracerebral challenge of monkeys, however, indicated that it still caused paralysis and death in occasional animals. In this connection it is important to point out that so far, no strains of poliomyelitis virus of Types 1 or 3 have been adapted to passage in chick embryos. Since Type 1 is responsible for more than 80 per cent of human paralytic cases, it would be of great value if a chick embryo adapted strain of Type 1 could be developed.

Enders *et al.*<sup>26</sup>, have found decreased infectivity for monkeys in a strain of Type 1 virus after prolonged propagation in cultures of human embryonic skin-muscle tissues. A strain of Type 2 virus showed diminished pathogenicity for mice after similar treatment. Whether a long continued series of such subcultures in various types of tissues will lead eventually to the development of stable nonpathogenic strains, that retain their original antigenicity, has not yet been determined.

Sabin<sup>27</sup> is using a slightly different approach; rapid serial passage of large amounts of virus growing in cultures of monkey kidney tissue followed by terminal dilution passages. He feels he has been able to produce variants with diminished virulence for the central nervous system of cynomolgus monkeys but with no loss of antigenicity.

It has been felt by some workers in this field that a vaccine that could be administered by mouth would be preferable, since that is the manner in which natural infection usually occurs in man. Koprowski<sup>28</sup> has fed a strain of poliomyelitis virus of reduced pathogenicity to 81 children. The behavior of that particular strain on intracerebral inoculation into monkeys, is similar to the behavior of rodent-adapted Type 2 strains when they are injected into the central nervous system of primates. Of the children fed this virus, 41 [50.6 per cent] excreted the virus in their stools, and in 68 [84 per cent] there was a rise in homologous antibody.

#### SUMMARY

1. Basic discoveries made by many investigators in the past have suggested various mecha-

nisms by which paralytic poliomyelitis might be prevented.

2. A number of different ways of developing active immunity are under intensive study.
3. Encouraging results obtained by Salk in both animals and human beings with a trivalent formalin inactivated tissue culture vaccine indicate the need for a field trial of the effectiveness of this preparation under natural conditions.
4. Several different approaches to the development of mutant strains which might eventually be used as live virus vaccines are under investigation.

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## PULMONARY CYSTS

Cysts that have bronchial communications become infected, and eradication of this infection is not complete until the cyst is removed by surgery or spontaneous obliteration. It seems probable that all individual cysts originate in a single lobule of the lung. Adjacent healthy lung tissue suffers varying degrees of damage, depending upon the duration of the cyst, its size, and the intensity of the infection. Therefore, the conservative treatment of a cyst that compresses adjacent normal lung tissue should not be continued long enough to permit irreparable damage which in the end will result in the sacrifice of

a greater amount of lung tissue or in permanent crippling of the patient. The developing lung of young infants and children is more prone to develop cysts, but in these patients, the efficacy of conservative measures by the optimistic pediatrician and persevering thoracic surgeon has resulted in a clearing of a large percentage of cysts without sacrificing lung tissue. It is in this group that rapidly expanding cysts may occur, resulting in asphyxia and death if surgical intervention is not prompt. *J. Cash King, M.D. and Francis H. Cole, M.D., Pulmonary Cysts. Texas J. Med. Dec. 1953.*

# Recent Advances in Vaccines for Prevention of Acute Anterior Poliomyelitis

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The late Dr. William H. Park, famous scientist who originated diphtheria toxin-antitoxin, expressed his opinion to me about 1927 that it was a waste of time to work on a poliomyelitis vaccine because of the low attack rate for paralytic poliomyelitis which prevailed. Since then we have seen a steady increase in the incidence of this disease, until now it is the most important infectious disease of childhood in this country excepting rheumatic fever. The increased poliomyelitis attack rate now prevalent, due perhaps to the decline in opportunities for natural immunization, and the general fear of its sequelae makes everyone agree that a successful vaccine would be used generally.

Park changed his mind about poliomyelitis vaccine to the extent that he sponsored one of the two vaccines used in field studies in 1935 with such unfortunate results.<sup>1</sup> Even if these vaccines had been safe, it is doubtful if they would have proved effective. It was not then realized that there are at least three immunologic types of poliomyelitis viruses. The two vaccines used in 1935 probably contained a single antigenic type, probably what we now call Type 2. The only source of virus then available, monkey spinal cords, was too limited to supply enough vaccine for large scale use, since the cord from one monkey supplied only a few doses of vaccine. Also it is now known that crude monkey cord material, such as was used in the vaccines in question, may have made the vaccines dangerous by causing iso-allergic encephalomyelitis such as occurs too commonly following the use of antirabic vaccines.

The bad results accompanying the use of the Kolmer and Park-Brodie vaccines in 1935 stopped all poliomyelitis vaccine studies for a

time. In fact during this era it was questioned whether a poliomyelitis vaccine ever could be developed. Second attacks of poliomyelitis occurred in the same individual often enough to suggest that the disease did not immunize against itself. Second attacks can now be explained on the basis of the first attack being due to one virus type and the second to another.

It also was thought that poliomyelitis was a strictly neurotropic disease and that there was scant hope of immunizing against an infection which followed nerve pathways. It is now believed that the virus may invade the central nervous system from the blood stream.<sup>2</sup> Studies on animals have shown that antibodies may keep the virus from invading the blood stream and thus from penetrating the central nervous system.

Even before these new facts were known, the poliomyelitis vaccination problem was being re-studied. Morgan and others<sup>3</sup> demonstrated that monkeys vaccinated with live virus were able to withstand intracerebral injection of several thousand fatal doses of virus. Milzer, Levinson, and Oppenheimer<sup>4</sup> demonstrated that mice immunized with a vaccine produced by irradiation of Type 2 virus were immune to intracerebral challenge. Morgan,<sup>5</sup> demonstrated that monkeys could be immunized with formalinized vaccine. Howe<sup>6</sup> showed that chimpanzees and children developed good antibody titers after vaccination with inactivated virus. All these studies were done with vaccines made from monkey cord virus. It was realized that this was not a satisfactory source of virus but there was no substitute at that time. Type 2 virus had been adapted to mice years before but Types 1 and 3 have been adapted to mice by the intracerebral route only within the past few months.

Attempts to purify and concentrate the virus from monkey cords or the brains of rodents met with little success. Able investigators also had

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tried unsuccessfully to adapt the poliomyelitis virus to the chick embryo, that fantastically useful culture medium for growing other viruses and Rickettsiae for vaccine production.

What was needed was a new source of virus, abundant, cheap, and free from nerve tissue. In 1949, Enders, Weller, and Robbins<sup>7</sup> found that the three types of poliomyelitis viruses will multiply in human nonnervous tissues *in vitro*. The subsequent demonstration that monkey tissues, especially kidney, serve as media for the virus has made it possible to grow all three types in quantity and at reasonable cost. The impact of this development on poliomyelitis research was as great as or greater than the original isolation of the poliomyelitis virus in 1908. The tissue culture technic is useful in many ways other than for production of virus. However, since we are concerned here with vaccine production, it is sufficient to state that virus can be obtained now from tissue culture in titers as high as or higher than is obtainable in infected monkey cord and without nervous tissue. All our recent work has been done with this tissue culture material.

Since Dr. Kumm is presenting a report on the Salk vaccine,<sup>8</sup> the author will confine his remarks to the work which has been done by our group with an irradiated vaccine. Ultraviolet irradiation has been used in the preparation of our vaccine because in studies by ourselves<sup>9</sup> and others<sup>10</sup> over a period of more than ten years it seemed to offer a technic of virus inactivation that caused the least antigenic destruction. Our rather extensive experience with production of antirabic vaccine by this technic indicated a rather wide margin of safety between complete inactivation and destruction of antigen. Also, in the case of antirabic vaccine, the irradiated material is of higher potency than chemically inactivated vaccine and there is less deterioration after storage.

In the studies reported by our group<sup>11</sup> last year, Type 1 (Mahoney), Type 2 (MEF1), and Type 3 (Saukett) viruses were grown in monkey kidney tissue in the medium of Melnick and Riordan. The virus titers ranged from  $10^{-3.0}$  to  $10^{-5.5}$  and were lower than that of lots being prepared currently. Irradiation was carried out in two centrifugal filmers (Levinson-Openheimer) connected in series with a film

thickness of 25 microns at a flow rate of 200 ml. per minute. Total exposure time was two seconds and the ultraviolet energy absorbed in 2537 Å U was  $4 \times 10^{-6}$  Einstein per ml.

Originally, our safety tests consisted of inoculation of monkeys and cultures and sub-cultures in tissue culture, attempted photo-reactivation, and the usual bacterial sterility tests. The scope of these tests has been broadened after it became evident that tests must be made to rule out specific bacteria such as tubercle bacilli and viruses such as lymphocytic choriomeningitis and "B" viruses which may be carried into the tissue culture by the monkey kidney tissue. It must be noted that no one can be certain at this time that the present safety tests are adequate. The only adequate safety tests are those based on a comparison of results in animals and the inoculation of large numbers of persons. It appears, however, that data are available indicating that the present animal safety tests are adequate.

Normal adult volunteers were inoculated with trivalent tissue culture vaccine, inactivated by ultraviolet irradiation, with and without adjuvant. An injection of 1 ml. of vaccine (containing 0.17 ml. of each of the three types), plus purified mineral oil adjuvant, was followed by another injection of 1 ml. of trivalent aqueous vaccine one month later. Another group of volunteers received three 1 ml. injections of the aqueous vaccine at bi-weekly intervals. Blood specimens were taken before vaccination and two weeks after the second injection. Antibody titrations of the sera were made in monkey kidney tissue against 100 50 per cent tissue culture infectious doses of virus.

Antibody responses of fourfold or greater were shown by volunteers receiving the adjuvant vaccine as follows: 63 per cent against Type 1, 87 per cent against Type 2, and 90 per cent against Type 3. Similar results were obtained with the aqueous vaccine. Two points should be emphasized: first, all that was demonstrated in these tests is a booster effect since most of the subjects had some antibody titer prior to vaccination; second, these studies were done with a vaccine made from what we would now consider to be low-titer virus preparations and thus the vaccine was probably of low potency even when freshly prepared.

It was our intention to follow this work with

TABLE I  
Serum Titers (Type I) in Vaccinated Rabbits

Rabbit No.	Vaccine (all Type I)	Pre-Vacc. Titer	Post-Vacc. Titer
1	Active	<1:1	1:640
2	Active	<1:1	>1:320
3	Irradiated	<1:1	1:80
4	Irradiated	<1:1	>1:80

studies in young children who were devoid of antibodies to see if our vaccine preparations could stimulate antibodies *de novo*. A small scale study with children is under way but the results are not ready for presentation. Our group felt there are many problems that could and should be studied in the laboratory before carrying on more extensive clinical or field studies. Among the studies undertaken were: development of methods for bio-assay of the potency of the vaccine; studies of methods of obtaining better yields of virus per unit of monkey tissue; studies designed to make it possible to produce higher titer virus preparations; studies of immunogenicity of different strains of virus; effectiveness of irradiation in destroying contaminants such as tubercle bacilli and "B" virus; and studies of preventing undesirable side effects of vaccine.

In our opinion a method of bio-assay for determining potencies of different vaccines and different lots of vaccine is high on the priority list. It is essential that we have a tool with which to compare results with different preparations without using human volunteers. We have found that the quantitative determination of antibody production by rabbits inoculated with vaccines apparently gives a workable procedure for assaying relative potencies. The results of one test are shown in Table I. In this study two rabbits received seven 10 ml. injections of active Type 1 virus intravenously at weekly intervals, and two received a similar number of injections of 10 ml. each of the same virus inactivated by ultraviolet irradiation. Blood specimens were taken from all the rabbits one week after the last injection. The results with the irradiated vaccine are much better than might be expected and indicate little deterioration of the antigen as a result of irradiation. We believe this method may give results which parallel those in the human. For example, a vaccine of poor initial potency appeared to have lost

TABLE II  
Serum Titers (Type I) of Monkeys Receiving 3 x 5 ml. Injections Ten Times Concentrated Type I Vaccine

Monkey No.	Pre-Vacc. Titer	Post-Vacc. Titer (1 week after vacc.)	Pre-Booster Titer (1 month after vacc.)	Post-Booster Titer (1 week after booster)
29	<1:1	1:64	1:8	1:256
30	<1:1	1:32	1:4	1:128
56	<1:1	1:32	1:32	1:256
57	<1:1	1:64	1:8	1:128

its power to stimulate antibodies in human volunteers after long storage. Shortly afterward it was tested in rabbits and found to be virtually devoid of power to stimulate antibodies.

Studies carried on in monkeys have indicated that a certain minimum level of antigen seems necessary to trigger the immune reaction. One of our earlier vaccine preparations which we now know to have been of low potency failed to stimulate antibody production to any detectable level in any of four monkeys tested. When similar preparation was concentrated somewhat less than tenfold, it stimulated good antibody responses in monkeys as indicated in Table II. It may be stated parenthetically that monkeys are extremely difficult to immunize, even with live virus, and titers of 1:8 after a course of vaccination with inactivated virus are considered satisfactory. Titers of 1:128 or 1:256 in monkey sera are, therefore, quite high and indicate that the preparations used to stimulate them should be capable of producing good antibody titers in young children. With the richer virus fluids now being harvested, it is believed that vaccines of at least equal potency can be prepared without concentration.

This discussion has been centered around antibody stimulation because that is the only immunity reaction that anyone has demonstrated by the use of tissue culture vaccine to date. No one knows what level of antibody is necessary for solid immunity in human beings. On the basis of the first gamma globulin studies<sup>12</sup> it was thought that low levels of antibody, on the order of those demonstrable in undiluted serum, would suffice. These assumptions have had to be modified by the later findings on gamma globulin. The antibody levels produced by vaccines are far higher than those from gamma globulin.

It appears that antibody levels stimulated by vaccines are of the order of those found against

the homotypic virus in individuals who have recovered from poliomyelitis: presumably, the latter levels would be protective. After a primary course of vaccination, however, there is a sharp drop in antibody titer within a few weeks or months in both animals and man. The titer can then be brought to higher levels than the former peak by a recall dose of vaccine. How long these higher levels of antibody persist is not known. Possibly annual booster injections may be necessary if high antibody levels are necessary and cannot be otherwise maintained.

The relation of antibody level to solid immunity to poliomyelitis viruses in man can be answered only by field trials of the type now being carried on a nationwide scale by the National Foundation for Infantile Paralysis. It may be that vaccinated individuals whose antibody levels drop to a low point several months after vaccination are still capable of mobilizing antibodies quickly enough to repel invasion by the virus.

In the field trials now under way should prove vaccine is effective, there is no guarantee that vaccination will continue to be successful in the future. The first field trials with influenza vaccine were successful but new serologic types of influenza virus have arisen. There is evidence that more than three types of poliomyelitis viruses may exist and we may be facing a repetition of the influenza immunization situation. Strains of viruses other than those now being used in vaccines may prove to have broader antigenicity, covering the whole antigenic spectrum including as yet undiscovered types. These are problems for the future.

Inactivated virus vaccines, whether prepared by formalin, ultraviolet irradiation, or other methods may not prove to be the answer to immunization against poliomyelitis. It may be, as contended by some immunologists, that only a vaccine prepared from live, attenuated virus will produce solid, lasting immunity. The rodent-adapted virus of Koprowski and associates<sup>13</sup> has been fed to two large groups of children without ill effect. Antibody titers produced by a single feeding were high and apparently persisted well. It has yet to be shown that similar vaccines can be prepared against Types 1 and 3 viruses. Since persons fed the Koprowski vaccine excrete large amounts of virus for several weeks, public health officials will have to be convinced that the at-

tenuated virus will not regain its virulence by passage from person to person.

Cabasso and his co-workers<sup>14</sup> have adapted Type 2 virus to the chick embryo and this may be the source of another attenuated virus vaccine. Sabin<sup>15</sup> and others are attempting to produce an attenuated vaccine that can be grown in tissue culture and given parenterally so that there is no excretion of virus. While investigations of this type are highly important, it may be years before a vaccine produced in one of these ways reaches the practical stage.

Meanwhile, "killed" virus vaccines may be useful even if annual re-vaccination should prove necessary. It is conceivable that attenuated vaccines will be so effective there will be no need to search further for an attenuated vaccine. It is to be devoutly hoped so; it is time this killer and crippler be brought under control.

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# Plan of Distribution of Gamma Globulin in Illinois in 1954

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**Springfield**

Despite the somewhat increased supplies of gamma globulin available to the states for use in 1954, and despite the failure to demonstrate any effectiveness of its use in poliomyelitis prophylaxis in the mass inoculation areas in 1953 as well as its ineffectiveness among the household contacts of polio cases, this biologic must remain under control for the present. Control of distribution was again made necessary since the vast bulk of the nationally available globulin has been allocated for use in group situations in poliomyelitis to be defined, more or less, below. The supply of gamma globulin for *measles* and *infectious hepatitis* contacts will, however, be adequate for anticipated needs in Illinois this year.

## 1. Restrictions for Use

**NO GAMMA GLOBULIN WILL BE UTILIZED FOR THERAPY.**

### A. Measles Contacts:

In general, gamma globulin will be available for prevention or modification of measles among all susceptible child contacts of measles cases.

#### 1. Indications for Prevention:

a) Children *under 3 years of age* — to obviate bronchopneumonic complications.

b) In older children already ill with other diseases — to prevent aggravation of the existing illness.

c) Among pregnant women, especially in the later months of pregnancy, who have never had measles and hence, are susceptible, who have been in contact with a measles case and whose

physicians feel the disease may complicate pregnancy or labor. This may also be helpful, if exposure of such rare susceptibles occurs just prior to labor, for it may obviate exposure of others in the maternity ward.

#### 2. Indications for Modification:

a) Children over 3 years of age — to prevent complications but permit immunity to develop.

#### 3. Dosage and Administration:

a) For *prevention*: 0.10 to 0.125 cc. per lb. of body weight (or by age according to table below).

b) For *modification*: 0.02 to 0.025 cc. per lb. of body weight (or by age according to table below).

#### c) Age-dose table for measles contacts:

Age	Prevention	Modification
Up to 6 months	2 cc.	—
6 months to 3 years	3 cc.	—
Over 3 years	1 cc. per year	0.2 cc. per year
Susceptible pregnant women (rarely)	20 cc.	—

d) Injection must be *intramuscular*.

e) Injection of contacts should be performed as soon as possible after exposure so that desired prevention or modification may better be achieved.

### B. Infectious Hepatitis Contacts

1. *Household Contacts* — All household contacts of infectious hepatitis cases are eligible to receive gamma globulin, *irrespective of age*.

#### 2. Classroom Contacts in Schools

a) Wherever a case of hepatitis has occurred

in a schoolroom and there is evidence of exposure of classmates by the child's having been present in class during the infectious prodromal phase or during the first week of illness prior to the development of jaundice, gamma globulin may be made available to all contacts in the classroom. Such situations must be cleared with the full-time city, county or regional health officer and the latter will consult with the Illinois Department of Public Health for permission to release the gamma globulin.

b) The extent to which this program may be operated will depend upon continued availability of globulin for this purpose for the year. Schools with more than one case and exhibiting signs of portending outbreaks, or schools with but a single case located in communities with rising incidence of the disease in the general population may have to be given priority if gamma globulin supplies are too rapidly depleted.

c) For administrative ease of execution and control of contacts to be inoculated, prophylaxis should be carried out on a "school program" basis. In this way, a majority of such contacts would be inoculated in the shortest period of time following exposure so as to assure a high measure of protection.

### 3. Dosage and Administration

a) For most effective prophylaxis, 0.06 cc. per lb. of body weight is adequate. Protection has occurred, however, at dosage levels of 0.02 cc. per lb. (see age-dose table below)

b) Gamma globulin of the type utilized for measles prophylaxis is to be dispensed for infectious hepatitis prophylaxis.

#### c) Age-dose Table for Hepatitis Contacts:

Age	Dose
Under 1 year	1 cc.
1-4 years	2 cc.
5-20 year	1½ cc. per year
Adults	10 cc.

d) Injections must be *intramuscular*.

e) Injection of contacts should be performed as soon as possible after exposure so that desired prevention may be achieved.

### C. German Measles Contacts

1. Only susceptible women in the first trimester of pregnancy exposed to a case of German measles are eligible.

2. Protection is not entirely reliable since antibody content is probably extremely variable

among different lots of gamma globulin. Convalescent German measles serum, where available, may be more efficacious.

### 3. Dosage and Administration:

a) 20 cc. gamma globulin should be administered as soon as possible after known exposure.

b) Injection must be *intramuscular*.

### D. Hypogammaglobulinemia

1. Cases, proven by laboratory techniques,\* to be hypogammaglobulinemia are eligible for gamma globulin.

2. These occur but rarely and dosage to be administered will be determined by clinical needs.

### E. Poliomyelitis Prophylaxis

1. Household contact inoculations have been shown *ineffective* and this use of gamma globulin *will not be permitted this year*.

\*Electrophoretic patterns of blood protein content.

2. Individual contacts to cases, except pregnant women, are *not* eligible for gamma globulin unless they are members of a large "group."

### 3. Group inoculations

a) Gamma globulin will be available, if desired, for inoculation of groups of children other than in single family units.

b) No rigid definition of "group" is available and the Federal Office of Defense Mobilization has merely cited examples of *neighborhood, area or district* within a community or a community as a whole. Other examples include *apartment houses, housing projects, summer camps, day nurseries, classrooms, institutional groups, etc.*, though each has its epidemiologic objections of concurrent infection with the case, high immunity levels or difficulties in outbreak prediction among population groups of any type or size.

c) Use of gamma globulin for modification of severity of the disease in any group situation is open to question in view of the negative findings in the 1953 studies.

d) If globulin is applied in group situations, the age-groups most vulnerable to attack would best be given prior consideration.

e) Pregnant women may also receive such inoculations.

4. The full-time health officer of the area and the local medical group will *jointly* determine the feasibility of group inoculations.

## 5. Dosage and Administration:

a) Dosage is 0.20 cc. per lb. body weight (or by age as in table below).

b) Age-dose table:

Age	Dose
Under 6 months	3 cc.
6 mos. thru 2 years	5 cc.
3 yrs. thru 15 years	1.5 cc. per yr.
Pregnant women	30 cc.

c) Injections must be *intramuscular*.

### 1. Distribution Centers

A. The *same centers* distributing gamma globulin last year will serve as distribution points in 1954. These are:

1. All *full-time* city, county and district health department offices (see attached list)
2. Regional offices of the State Health Department (see attached list)
3. Division of Preventive Medicine, Illinois Department of Public Health, Springfield (Phone: 6611, Extension 167).

## III. Requisitioning Gamma Globulin by Physician

A. Select nearest center geographically (or center on most rapid mail route to community).

B. Have data on *case* (name, address, age and date of onset) and *contacts* (name and age) ready.

C. Preferably, phone request to center (or mail request slip to center) giving all information above (B).

D. Gamma globulin in calculated amount will be shipped immediately by special delivery mail, or

E. Member of family or physician's agent may obtain the gamma globulin if he presents a physician's request form or prescription blank with the pertinent data and signed by the administering physician.

## IV. Issuance of Gamma Globulin by Centers

A. Issuance of gamma globulin will be *automatic* upon receipt of physician's request for eligible contact prophylaxis in:

1. Measles
2. Infectious Hepatitis
3. German measles

B. In hypogammaglobulinemia relatively larger continuous amounts may be issued when the condition is proven by laboratory findings.

C. Requests for group inoculations for polio-

myelitis should have the approval of the full-time city, county, district or regional health officer in consultation with the local medical group to be involved.

## D. Amount to be Issued

1. Where weights for contacts are given, utilize respective doses indicated for each disease above.

2. Where *age* alone is given, utilize age-dose tables for the respective diseases.

3. In prophylaxis of *measles* and *infectious hepatitis*, round off calculated amounts to nearest 2 cc. vial (for hepatitis, both 10 cc. and 2 cc. vials are available; in pregnant German measles contacts, 2 — 10 cc. vials will universally be issued)

a) Only supply designated for measles and hepatitis will be used.

4. In *poliomyelitis group inoculations*, 10 cc. vials will be used on a mass basis (see I. E. 3 above)

a) Only supplies earmarked for poliomyelitis will be used.

## V. Maintenance of Stocks and Replacement

### A. Records

1. Distribution centers will demand a physician's request slip (or prescription blank with pertinent data) for issuance of gamma globulin.

2. Distribution centers may desire to keep local records of distribution. Forms distributed last year may be employed. Original request slips are to be utilized for replacement of gamma globulin.

3. In group inoculations for poliomyelitis, a listing or children's name and their ages will be forwarded to this Division immediately after inoculations are completed. DESIGNATE TYPE OF GROUP.

### B. Replacement of Gamma Globulin

1. Physician's request slips or prescription forms will be forwarded to the Division of Preventive Medicine, Illinois Department of Public Health once each week (or oftener if supplies are rapidly depleted) for replacement of gamma globulin stocks.

2. Replacement will be made in vial sizes according to disease for which issued.

### C. Inventories

1. IMPORTANT! Stocks of gamma globulin, ear-

marked for measles, infectious hepatitis (and German measles) on the one hand and for poliomyelitis on the other, *must be maintained separately!* This must be according to physical count, requisitions for replacement and receipts, and irrespective of labeling, since certain supplies earmarked for measles and hepatitis may, at times, be labeled "Immune Serum Globulin" and at other times "Poliomyelitis Globulin." Shipments from the Central Storeroom will be designated as "Replacements for Measles or Hepatitis" or "Replacements for Poliomyelitis" as the case may be.

2. From time to time, inventories will be re-

quested as calls for such are made by the Public Health Service.

#### VI. *Utilization of Request Slips as Morbidity Records by Local Full-time Health Departments*

A. Physician's request slips contain minimum data on cases for official morbidity reporting. These should be utilized as a source of such reporting.

B. The total count of measles and hepatitis cases becomes important since gamma globulin is allocated to states on the basis of reported morbidity from these diseases.

For information and procurement of Gamma Globulin, consult your City, County, Local District or Regional Health Department.

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## STERIODS AND CANCER

Many facts seem to link the pathogenesis of some cancers with the steroid hormones. It has been known for many years that the anatomical structures which these substances affect such as the breast, uterus, and prostate, are predisposed to malignant change. Certain of the steroid hormones, and particularly the estrogens, have induced cancer in experimental animals. Cancer of the breast and prostate can be stimulated or retarded by hormone therapy or by the removal of the ovaries or testes. Cancer of the prostate is unknown in eunuchs and breast cancer is rare in ovariectomized women. Cancer develops with greatest frequency at the time of life when changes are occurring in the endocrine balances. There is a close structural relationship between the steroid hormones and many of the chemical substances that will induce cancer in experimental animals. These and similar related facts fall far short, however, of explaining all types of cancer. In partial ex-

planation, it has been pointed out that each individual has a characteristic pattern of steroid hormone excretion and, consequently, of steroid hormones in the body. During the process of aging, the production and metabolism of these hormones undergo numerous changes. As the balance of the various steroids shift, it seems possible that certain steroids with greater carcinogenic properties are manufactured in greater quantity in the body. It also has been suggested that some new substance with high cancer-producing properties may be formed, and subsequently released to exert its effect on any susceptible tissue. Possibly such a defect in the metabolism of the steroid hormones in some localized tissue area may be responsible for the initiation of a malignancy at that particular site. In view of these possibilities, intensive research on steroid hormone metabolism in relationship to human cancer is being conducted in several cancer research centers. *The Origin of Cancer. Cancer Bulletin. Nov.-Dec. 1953.*

## EDITORIALS



### **MEDICAL RELATIONS UNDER WORKMEN'S COMPENSATION**

For some time the Committee on Industrial Health of the Illinois State Medical Society has been engaged in a study of medical relations under workmen's compensation in Illinois. On April 29, 1954, with the approval of the Council, the Committee issued its report accompanied by the following letter:

"The primary purpose of the enclosed brochure entitled "MEDICAL RELATIONS UNDER WORKMEN'S COMPENSATION IN ILLINOIS" is two-fold:

- "1. To inform the medical profession concerning statutory provisions and actual practices under these provisions in the highly technical field of workmen's compensation, and
- "2. To encourage action by the medical profession in the correction of abuses and needed elevation of standards of medical care and administration as disclosed in the report.

"This report is not to be considered as an all-inclusive analysis of workmen's compensation nor as a criticism of any particular administrative agency in Illinois. The undersirable aspects of workmen's compensation have developed over a period of many years because many of those directly concerned have lost sight of the original intent of workmen's compensation legislation.

It is hoped that this report will encourage others to scrutinize their particular areas of responsibility.

"We recognize that every doctor has a major responsibility in the proper administration of workmen's compensation, both professionally and as a citizen of the State of Illinois. We are taking the necessary steps to fulfill our share of this responsibility. The medical profession realizes that it cannot do this whole vitally necessary job alone.

"Will you join with us in providing Illinois workmen with the workmen's compensation program to which they are entitled?

Willis I. Lewis, M.D., President  
Illinois State Medical Society

F. Lee Stone, M.D., Chairman of the  
Council, Illinois State Medical Society

Lloyd E. Hamlin, M.D., Chairman  
Committee on Industrial Health  
Illinois State Medical Society"

The information in this report was recorded after interviews with numerous well-informed, objective individuals who have had substantial experience with the workmen's compensation system in Illinois for a number of years. Those interviewed represented all interested groups — labor, industry, insurance carriers, the legal and

medical professions as well as past and present officials of appropriate state agencies.

Since the issuance of its report, the Committee has met several times with the Illinois Industrial Commission and various groups representing labor, industry and the legal profession. At these meetings the Committee has asked for constructive suggestions and cooperation in the improvement of medical relations under the Illinois system of workmen's compensation. The reactions and suggestions of the Commission and the various groups have been notable for their sincerity, variety and interest.

Some instances of misinterpretation by the press of the intent and text of the Committee's report and accompanying letter might well have served as a deterrent to cooperative action had the members of the Commission and the various groups been less able and genuinely interested in resolving the many complex problems presented by the Illinois system of workmen's compensation. Determination to cooperate in providing injured workmen with an outstanding program has been the dominant factor in these discussions.

The Committee on Industrial Health salutes its comrades in this important program and looks forward to continued progress.

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## **F. GARM NORBURY, M.D., PRESIDENT-ELECT**

At the closing session of the House of Delegates of the Illinois State Medical Society on May 21, 1954, Dr. F. Garm Norbury of Jacksonville was elected President-Elect of the Society. Dr. Norbury is the son of Dr. Frank Parsons Norbury who for many years was an outstanding neuropsychiatrist in Illinois and the Middlewest, and who established the Norbury Sanatorium in Jacksonville in 1901.

Frank Garm Norbury received his medical training at Harvard Medical School in Boston, then had an internship and assistantship in pathology at the Boston City Hospital. During World War I, the Chief of Laboratory Service, Base Hospital number 7, American Expeditionary Forces and Bacteriologist of the Meningitis Commission of the A. E. F. He became associated with the Norbury Sanatorium in 1919 and was Associate Physician until 1939 when he became its Medical Director. Between 1942 and 1946,

he was Commanding Officer of the 83rd General Hospital, a neurosurgical hospital in the European Theater of Operations and after V-E Day was Consultant for Military Government of Germany (U.S.) with special interest in civilian hospitals in the United States Zone in Germany.

Dr. Norbury is a Fellow of the American College of Physicians; member of the American Board of Psychology and Neurology; American Psychiatric Association, and the Central Neuropsychiatric Association. He has retained membership in the local County Medical Society, the Illinois State Medical Society and The American Medical Association. When Dr. Walter Stevenson of Quincy became President-Elect of this Society several years ago, Dr. Norbury was elected to serve the unexpired portion of the three year term as Councilor for the Sixth Illinois Councilor District.

He has long been a delegate from the Morgan County Medical Society in the House of Delegates of the Illinois State Medical Society. Dr. Norbury has three children and five grandchildren, — Mrs. Norbury passed away in 1951. Dr. Norbury is well known to many members of the Illinois State Medical Society, all of whom predict that he will always work for the best interests of this Society and aid in every way to further increase the standards of health for the citizens of Illinois.

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## **SUPPORT MEDICAL SCHOOLS**

Dr. Brian Bird, of Western Reserve University School of Medicine, made a proposal in the June issue of the Journal of Medical Education, that medical students be billed for their education and pay it back within a certain number of years after graduation.

The suggestion is good except that no one knows how much it cost to educate a medical student. Universities estimate that tuition pays only one-fourth to one-third, and the total cost is an inclusive term without precise meaning. It may include the education of students in related medical fields. In addition, the total cost must be divorced from that of research and service in the community. It is the public that benefits from these values and it is not entirely fair to ask medical students or students in other schools of the university to pay for this research and service.

Schools have been negligent in not informing people of the value of their activities. One of the little known services performed by the five medical schools of this state was brought to light recently by the secretary of the Winnebago County Medical Society. This organization opposed the addition of \$20 to the dues of the Illinois Medical Society that was earmarked for the American Medical Education Fund.

"I went to the Illinois State meeting Thursday, May 20, 1954, fully convinced that the compulsory assessment levied by the I.S.M.S. for the A.M.E.F. was a bad thing, and had been more or less rammed down our throats. My first doubts came during luncheon with Dr. Maurice Hoeltgen, secretary of the Chicago Medical Society, who pointed out that relations of the rank and file physicians with medical school deans and full-time faculty members had improved tremendously since the A.M.E.F. had collected and was distributing sums of money that actually were helping the medical schools with their financial problems. The deans and faculty members have co-operated wholeheartedly in all postgraduate programs and educational projects and this warm, friendly attitude was a pleasant change from the previous chilly relations. Dr. Hoeltgen, for one, hoped that our resolution would not pass because he wanted the deans and faculty members to continue to feel that all physicians were interested in the medical schools and the students following in our footsteps.

"I attended the House of Delegates meeting and our delegates did a noble job for us. During the discussion from the floor a physician delegate gave an impassionate plea against our resolution pointing out the role medical schools were playing in caring for the indigent, staffing charity wards, and giving help where the average physician had little time. He pointed out that compulsion collected the money and it would not be collected on a voluntary basis; and in our hearts I think we would have to agree. It was quite obvious that the feeling of the entire House of Delegates was against our resolution. This action I feel sure was not rammed down our throats. The rank and file of physicians in Il-

linois want it and I think we should accept our defeat gracefully and go along with the majority rule. The problem should now be ended once and for all."

We wish to take this opportunity to congratulate their secretary, Dr. W. S. Keenan, for taking this view. We also believe that closer co-operation between the medical schools and the county medical societies is a healthy sign of progress. We hope that other state medical societies will follow our lead.

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## THE SCIENTIFIC REPORT

Times are changing. A physician who plans to present a scientific paper before a medical society writes not only for his colleagues but for the public. A speaker often is asked to submit a copy of his talk to the secretary, in advance of its presentation, so that the public relations department may use it for home consumption. The talk is made available to science writers who usually dissect the material, using whatever part they think will interest their editors and readers.

The material that reaches the paper usually is accurate and complete. In some instances the meat of the article is omitted and a trivial point makes the headlines. If the material presented is old or too complicated for a science writer to understand, it does not make the news and the physician may be disappointed at the failure. A learned dissertation on the maturation of the megakaryocyte or the myoelectric studies of the paralyzed muscles on 1,000 cases of polio never will make the papers even though such subjects represent years of research and offer valuable contributions to medicine. On the other hand, the beneficial effects of whisky or cough drops on the common cold, even though not backed by scientific medicine, is a "natural." Many speakers are aware of this public relations practice and include ideas geared to public interest. Others, more subtle, will incorporate several sensational statements aimed to catch the attention of the science writer.

The only conclusion we can reach is best described in the old ditty, "Round 'n round she goes, and where she stops nobody knows."

## THE P.R. PAGE



### The P.R. Dinner

The third annual Public Relations dinner during the annual meeting was acclaimed a success. The total attendance was 105, the first time it has topped 100. This was accomplished in spite of the fact that this year everyone picked up his own tab. Many Woman's Auxiliary members were present.

The Chicago Medical Society delegation was largest by far, with nearly every branch of the Society represented. Multiple delegations were noted, however, from several other counties, including Winnebago, Macon and Peoria. More than 25 counties were represented, including practically all the larger ones.

The speakers kept it interesting. Harrison C. Putman, Jr., M.D., Peoria County P.R. chairman, presented a brief review of Peoria's program, as developed in the last two years under himself and M. Thomas Gorsuch, M.D., his predecessor as chairman.

Frank E. Wilson, M.D., director of the Washington office of the American Medical Association, then gave the principal address on the role of county societies in national legislation. Dr. Wilson's theme — and he laid it emphatically before the county P.R. chairmen and other officers — was that county level programs are essential to any national level legislative program. And if medical men want to exert an influence on legislation, they need first to clean

their own house by a sound public relations program and set up and maintain effectively the machinery for contacting legislators and explaining to them the medical viewpoint.

The Committee on Medical Service and Public Relations wishes to thank all of those members who so devotedly supported the P.R. dinner and promises an even more effective program next year.

### New Parlor Game?

Medicine needs some new cliches. Especially for referring to the scheme of lifelong security currently prevalent in Great Britain. It was originally tagged the "cradle-to-grave program," then some more gifted phrasemaker sneered at it in rhyme with "womb-to-tomb." That was all right for a while, but it is now worn down to the cliché status by over use and we need some new ones.

So please get out your rhyming dictionaries and let's see what can be done. All printable phrases will be reproduced here eventually with credit and thanks. Here are some samples:

"Birth-to-earth"  
"Sperm-to-worm"  
"Hay-to-clay"  
"Virgin-to-dirgin"  
"Make-to-wake"  
"Seed-to-weed"  
"Whistle-to-thistle"

Obviously, that could go on for a long time. Maybe the American Medical Writers' Association should make a project of it. The elimination of cliches from medical writing is certainly an aim worthy of its skills. Then we could present the whole list to the newspapers, perhaps with a time limit on use, beyond which they will also be considered cliches and we would have to dream out some new ones.

### **Illinois Overlooked**

There was a nice but naive piece in the Reader's Digest for May about the good job done in Virginia in dealing with the "doctor shortage." Led by a sociologist, though with medical support, the Virginians formed a state council and studied the situation, then went to work on getting physicians to rural towns. Since 1951, they have placed 58. The American Medical Association is quoted as calling the program "one of the best, if not the best, in the nation."

That is nice for Virginia, certainly, and the Virginians deserve all credit for doing the job that needed to be done there, which was all that was necessary.

But closer home, a bigger, broader and better job has been in progress for an even longer time. The Illinois State Medical Society recognized the need several years ago and, with the cooperation of the Illinois Agricultural Association, has done a remarkably effective job.

The joint medical student loan fund alone has more than 50 country boys studying medicine through cash loans made on their promise to return to their home towns to practice.

And the Physician's Placement Service in the secretary's office at Monmouth has, in addition, found places for doctors, or vice versa, in more than 125 towns in downstate Illinois in the last three years.

The Health Improvement Associations, formed by the Illinois Medical Service with Society support, now operating in nearly 80 counties to bring group insurance to rural residents, have gone further in educating the farmer healthwise and recruiting student nurses to back up the new doctor. The forty or more new hospitals downstate have also helped attract doctors to rural practice.

Illinois' problem was much bigger and it took a lot of doing, but it is being well done.

### **Medical Forums**

The Knox County Medical Society recently staged two successful forums on health subjects for the people of Galesburg and vicinity. The first, dealing with heart disease, attracted 215 persons, while the second, on cancer, brought out 350. Each time despite heavy rain.

Charles A. Ross, M.D., Knox P.R. chairman, reported to the society that the reception accorded the two forums has the Committee seriously considering presentation of several more dealing with similarly popular subjects.

The forums were presented with the cooperation of the Galesburg Register-Mail and School District 205 (for auditorium and sound equipment, the American Cancer Society and the American Heart Association (for films), Galesburg radio station WGIL (for promotion), and the Knox Women's Auxiliary, whose members distributed posters and otherwise helped in publicity, and the nursing staffs of both local hospitals, which supplied nurses as ushers.

Forums can be rather complex affairs and certainly take much hard work in organizing and presentation. In Chicago last winter the Tribune staged six of them, which were picked up by WGN and WGN-TV, with great success. They have been found to be a highly satisfactory method of getting sound medical information to the public and every society downstate which is large enough to swing the job should now be planning for next season.

### **Expert Testimony**

The recent report on "Medical Relations Under Workmen's Compensation in Illinois" which presents medical practitioners in a something less than favorable light, has renewed interest in expert testimony in courts. Many physicians reject such work for fear of having to testify and to submit themselves to harassment by opposing attorneys and loss of time. This question has definite public relations aspects.

The Committee on Industrial Health has the situation in hand and is meeting with other interested groups — bar, employers, labor, Industrial Commission, etc. — in the hope of cleaning up a menacing state of affairs.

Meanwhile, it seems proper to direct the attention of medical men to an article in the weekly Science (Vol. 119, P. 819, June 11, 1954) on

the principles which should guide scientific men in giving expert testimony. Written by Wilmer Souder, for 39 years a scientific staff member of the National Bureau of Standards, it is too long to reproduce, but every physician who might be called into court should read it.

Mr. Souder points out that the scientific man on the witness stand, is discussing his special field, not in the usual group of fellow-practitioners, but among laymen and strangers. The need for clear explanations is obvious. He also explains the legal status of a man qualified as an expert and the special responsibilities involved.

The various steps in the legal process, all taken in obedience to well-established principles, even though the witness does not understand them, are explained in turn as they affect the scientific witness. Much of the article is devoted to valuable tips on the pitfalls of cross-examination and how to avoid them.

### **I.S.M.S. Speaker Honored**

Nicholas P. Dallis, M.D., of Toledo, creator of the "Rex Morgan, M.D." strip, was honored at the American Medical Association meeting in San Francisco with a special citation for outstanding service in health education. Dr. Dallis, a psychiatrist, graduate of Temple University School of Medicine, writes the text for the strip under the pen name of Dal Curtis.

Dr. Dallis will be remembered here for his appearance with the two artist members of his team as the principal speaker at the annual dinner this year. It was their first attempt at presenting their story in the fashion. Several top representatives of the American Medical Association attended to see and hear them tell their story, as did delegations from other state societies, also anxious to invite him. He asks no fee for his appearance before medical groups, and the trio stages a really fine show.

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### **DON'T TAKE UMBRAGE**

If the patient expresses his own opinion about the diagnosis or the treatment of his illness, the physician does not take umbrage because he is aware of the vast amount of medical information which is available to lay persons; and he remembers too, how he was wont to diagnosis his own symptoms during his years as a medical student. In his relationship with his patient, the doctor avoids talking about himself, his family, his friends, and other physicians. He avoids assuming an artificial attitude of author-

ity or one of omniscience, and he accepts any justifiable criticism of himself or his nurse which the patient may make. He is never afraid of his patient. Not being afraid, he does not yield to requests which his patient may make and with which he does not feel in accord. His patient may express momentary resentment but will simultaneously experience renewed esteem and confidence in his physician. *Leo H. Bartemeier, M.D., Progress Of Psychiatry And The Utilization Of Its Principles In The Daily Practice Of Medicine. World M.J. Jan. 1954.*

## CORRESPONDENCE



### ELI LILLY MAKES GRANTS

The Research Grants Committee of Eli Lilly and Company has approved a grant to support the Fifth Congress of the International Society of Hematology. The congress will be held September 6-12 at the Sorbonne in Paris.

Other Lilly grants approved recently to support research projects in universities and hospitals include the following:

*University of Illinois:* Dr. L. M. Henderson, department of chemistry and chemical engineering; studies of the antithyrototoxic factor  
*Northwestern University:* Clifford J. Barborka, M.D., Medical School; studies relative to 'Elorine Sulfate' (Iricyclamol Sulfate, Lilly)

### CLINICS FOR CRIPPLED CHILDREN LISTED FOR AUGUST

Eighteen clinics for Illinois' physically handicapped children have been scheduled for August by the University of Illinois Division of Services for Crippled Children. The Division will conduct 13 general clinics providing diagnostic orthopedic, pediatric, speech and hearing examinations along with medical social and nursing services. There will be 4 special clinics for children with rheumatic fever and 1 for cerebral palsied children.

Clinics are held by the Division in cooperation

with local medical and health organizations, both public and private. Clinicians are selected among private physicians who are certified Board members. Any private physician may refer to or bring to a convenient clinic any child or children for whom he may examination or may want to receive consultative services.

The August clinics are:

August 3 — Macomb, Marietta Phelps Hospital

August 4 — Hinsdale, Hinsdale Sanitarium

August 5 — Litchfield, St. Francis Hospital

August 10 — East St. Louis, Christian Welfare Hospital

August 10 — Peoria, St. Francis Children's Hospital

August 12 — Effingham, St. Anthony's Memorial Hospital

August 12 — Elmhurst (Rheumatic Fever), Memorial Hospital of DuPage County

August 12 — Springfield, St. John's Hospital

August 13 — Chicago Heights (Rheumatic Fever), St James Hospital

August 18 — Chicago Heights, St. James Hospital

August 19 — Rockford, St. Anthony's Hospital

August 19 — Tuscola, Court House  
 August 24 — Effingham (Rheumatic Fever),  
 St. Anthony's Memorial Hospital  
 August 24 — Peoria, St. Francis Children's  
 Hospital  
 August 25 — Elgin, Sherman Hospital  
 August 25 — Springfield (Cerebral Palsy),  
 Memorial Hospital  
 August 26 — Bloomington, St. Joseph's Hos-  
 pital  
 August 27 — Chicago Heights (Rheumatic  
 Fever), St. James Hospital

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### **COURSES IN NEWER DEVELOPMENTS IN CARDIOVASCULAR DISEASES**

A course in "Newer Developments in Cardiovascular Diseases" will be given at The Mount Sinai Hospital, New York, October 11th through 15th, 1954, under the auspices of the American College of Physicians. As the title implies, the recent advances will be stressed. Dr. Arthur M. Master and Dr. Charles K. Friedberg will direct the course and prominent cardiologists and cardiac surgeons will participate.

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### **ANNUAL ASSEMBLY IN OTOLARYNGOLOGY**

The Department of Otolaryngology, University of Illinois College of Medicine, announces

its Annual Assembly in Otolaryngology from September 6 to 11, 1954. The entire week will be devoted to surgical anatomy and cadaver dissection of the head and neck, and histopathology of the ear, nose and throat. The Assembly will be under the direction of Maurice F. Snitman, M.D.

Registration will be limited. For information write to the Department of Otolaryngology, University of Illinois College of Medicine, 1853 West Polk Street, Chicago 12, Illinois.

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### **NEW PROCEDURE FOR REPORTING BLUE SHIELD CASES**

On July 1, all physicians were mailed a supply of the new Illinois Medical Service Report Forms. This enables physicians to initiate the process of case reporting immediately upon completion of service. Consequently, payment should be speeded by the elimination of much of the correspondence and phoning. Information as to filling out the new forms accompanied the supply.

After the form is completed, it should be sent to the Case Service Department, Illinois Medical Service, 425 North Michigan Avenue, Chicago 90.

If there are any questions about the procedure, please write or phone MOhawk 4-7100, Extension 480.

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### **DIAGNOSIS OF CANCER**

The lessons learned from the vast experience which has accumulated in the field of cancer research indicates that particular attention must be given to the further refinement of methods which are currently useful, but which still remain much less sensitive than is needful. It is quite possible that new diagnostic aids for certain types of malignancy may be developed, but it is unlikely that a single cancer test for the screening of populations for all types of

these diseases commonly referred to as "cancer" ever will be found. Investigative sights must be trained upon the sharpening of biochemical and biological methods developed to aid in the detection of certain specific types of neoplasm; for the differential diagnosis of certain tumors, and for the measurement of neoplastic growth activity, either in terms of its initial manifestation or its first recurrence following therapeutic ablation. *Freddy Homburger, Diagnostic Tests For Cancer. Seminar, Fall, 1953.*

# NEWS OF THE STATE



## ADAMS

**Society News.**—George H. Vernon, M.D., director, Madison County Sanatorium, Edwardsville, addressed the Adams County Medical Society recently on "The Physician's Opportunity in the Diagnosis of Tuberculosis."

## CLINTON

**Society News.**—Harry Phillips, M.D., East St. Louis, addressed the Clinton County Medical Society in Breese, recently, on "Medical and Legal Aspects of Psychiatry and Treatment of Same".

## COOK

**Personal.**—Maurice H. Cottle, M.D., gave the J. Raymond Hume Memorial address at the Louisiana-Mississippi Ophthalmological and Otolaryngological Society on "Physiology of the Nose." A second paper at a section meeting presented by Dr. Cottle was "Changing Concepts in Surgery of the External Nose."

**Special Society Elections.**—At the annual meeting of the Chicago Dermatological Society, Dr. Julius E. Ginsberg was named as president; Dr. Edwin Smith, vice president, and Dr. Irene Neuhauser, secretary-treasurer.—Dr. John W. Ferrin was elected president of the Chicago Urological Society recently; Dr. Joseph H. Kiefer, vice president, and Dr. Don E. Murrar, secretary-treasurer.—At the May meeting of the Chicago Pediatric Society, the following officers were elected: Eugene T. McEnery, president; Maxwell P. Borovsky, vice president; Ralph Kunstatter, secretary. Noel G. Shaw, treasurer, and Ralph Spaeth, editor.—Dr. Justin M. Donegan, Evanston, was recently chosen president of the Chicago Ophthalmological Society; Dr. Bertha A. Klien, vice president; and James E. Lebensohn, councilor. Drs. Richard C. Gamble, Park Ridge,

and Frank W. Newell, Chicago, were reelected corresponding secretary and secretary-treasurer, respectively.

**Grants for Research.**—The Hektoen Institute for Medical Research wishes to announce receipt of the following grants: From the Yonnie Cohen Foundation, \$3600.00 for fellowship in cardiology; from the Olivia Sue Dvore Foundation, \$12,500 for the continuation of research in hematology; the Alfred O. Hergott Heart Fund through the Chicago Heart Association gave \$2100.00 for a fellowship in cardiology; the Dr. Jerome D. Solomon Memorial Research Foundation, an annual contribution of \$16,000 for continuation of research in liver diseases; the Squibb Institute for Medical Research, \$6,000 for hematologic research; and the Women's Division of the Dr. Leonard and Louis Weissman Medical Research Foundation, \$10,000 for isotope and protein research.

**Hospital News.**—The Michael Reese Alumni Association has elected Dr. Theodore Shapira as its new president. Other new officers are Drs. Herman Smith, vice president; Bernard M. Cohen, secretary, and G. J. Menaker, treasurer. All of the officers are from Chicago with the exception of Dr. Smith, who is from Des Moines, Iowa.

**Fellows Named for Graduate Work.**—Appointment of fourteen Fellows for graduate work at the University of Illinois Chicago Professional Colleges has been announced by Dr. Milan V. Novak, associate dean of the Graduate College.

Dr. Peter H. Dickinson, who holds a Fellow of the Royal College of Surgeons and the bachelor of medicine degree, has received a \$1,800 stipend for a 12-month period.

A \$1,200 fellowship for a year of graduate study

has been awarded to Miss Ann Hunsaker, who holds the bachelor's degree.

Miss Hunsaker is the first appointee to a fellowship under a recent revision of policy which opens the fellowship program to superior students presenting a baccalaureate degree with a scientific background. Previously only professional graduates and those offering master of science degrees were eligible.

Eleven \$450 summer fellowships have been awarded to students holding bachelor degrees. They are Alan R. Aronson, Mitchell L. Borke, Earle E. Crandall, Harold E. Elliott, David T. Ellis, Rodney W. England, Earl N. Feiwell, Henry A. Gould, Brian H. Huncke, Nicolaos Kefalides, and Gladys G. Krakow. Robert A. Liebelt, who holds the master of science degree, also has received a summer fellowship.

Fellowship appointees are exempted from tuition fees. Students usually qualify for graduate work in a basic science department and carry a full program of graduate study.

**Personal.**—Harry M. Hedge, M.D., has removed his office from 30 North Michigan Avenue, Chicago, to 636 Church Street, Evanston.

**Physicians Honored.**—St. Luke's Hospital recently presented twenty-five year service awards to Drs. Thomas J. Coogan, Nelson F. Fisher, Fred W. Hark, Edward C. Holmblad, Carl A. Johnson, Alvin Reid Morrow and Mr. David Evans, a trustee.

**Winners in Annual Competition of North Shore Branch.**—Arnold L. Tanis, Children's Memorial Hospital, placed first in the annual competition by interns and residents of Chicago hospitals, sponsored by the North Shore Branch of the Chicago Medical Society. Title of the winning essay, which brought first prize of \$80, was "Lead Poisoning in Children, Including Nine Cases Treated with E.D.T.A." Second and third place winners were Clarence A. Norberg, Veterans' Administration, Hines, and Stephen Contro, Michael Reese Hospital, for their respective works on "A Simple Technique for Arteriography and Its Clinical Applications" and "Chronic Effusive Pericarditis." Their cash prizes were \$60 and \$40, respectively.

**Eighty Years of Age.**—Edward A. Corcoran observed two events, May 23—his eightieth birthday and his fifty-second year in the practice of medicine. Physicians, nurses, friends and patients gathered at an informal reception in Dr. Corcoran's home to help him celebrate the occasion.

**Personal.**—Walter S. Priest, M.D., senior attending physician at Wesley Memorial Hospital, was named president-elect of the American College of Cardiology at its annual meeting in Chicago, May 29.

**Treatment in Psychiatry.**—On June 2, Daniel Blain, M.D., medical director, American Psychiatric Association and clinical professor of psychiatry, Georgetown University School of Medicine, de-

livered the last in the Fourth Annual North Shore Health Resort Lecture Series on Treatment in Psychiatry. Title of Dr. Blain's talk was "How the General Practitioner Can Contribute Toward Healthy Emotional Development."

**Research Funds.**—The U. S. Public Health Service has awarded two grants for research projects to be conducted by the University of Illinois College of Medicine.

A \$12,500 grant will continue to support the teaching program in the field of cancer at the Tumor Clinic. Dr. Danely P. Slaughter will direct the fund.

The Department of Anatomy has received \$2,862 for continuance of the electron microscopic study of the glomerulus, especially its basement membrane in normal and nephritic mice. The investigation will be conducted by Drs. Arthur Kirschbaum and Parke H. Simer.

## KNOX

**Society News.**—On May 20, the Knox County Medical Society held a business session, a considerable part of which was devoted to a discussion of the Red Cross Blood Bank and group insurance. A feature of the meeting was a film from the American Cancer Society showing types of cancer found in the mouth and throat.

**Medical Forums Success.**—The Medical Forums conducted by the Knox County Medical Society and the Galesburg Register-Mail on April 19 and April 26 were considered sufficiently successful to warrant the holding of similar conferences in the future. The first forum on heart disease was attended by 215 persons, while the second, on cancer, brought forth 350. Ben Baird introduced the first subject which was moderated by Merrill Beecher. Panel participants were Drs. J. A. Bowman, Frances Kap-Dayton, Roderick B. Howell, J. C. Redington, Fred Stansburg and Ray E. Thompson. The second forum was introduced by E. N. Nash and moderated by Frank Huff. Panel participants were Drs. Fred Hambrecht, William Johnson, Alex Duff, Milo Reed, Richard Bick, Charles Paisley, and Franz Length.

Station WGIL cooperated by providing the time; School District 205 by providing the auditorium; American Cancer Society and the American Heart Associations by lending films. The nursing staffs of Galesburg Cottage and St. Mary's hospitals and the Woman's Auxiliary to the Knox County Medical Society also gave able assistance to make the forums a success.

The following topics were suggested as the topic for discussion in future forums. Listed in the order of their popularity, they are: arthritis, nervous disease in children or child psychology, diabetes, ulcers, mental disease, tuberculosis, back trouble, thrombophlebitis, gallbladder disease, kidney trouble, surgery, obesity, high blood pressure, headaches, cerebral palsy, asthma and muscular dystrophy.

## LAKE

**Fifty Year Insignia to Dr. Proxmire.**—Theodore S. Proxmire, M.D., Lake Forest, was inducted into the Fifty Year Club of the Illinois State Medical Society at the June 8 meeting of the Lake County Medical Society. Following the presentation of the insignia to Dr. Proxmire, a panel discussion on "What A County Board of Health Would Mean to the Doctors and People of Lake County" was held. Walter Ready, Chairman of the Public Health Committee, Lake County Medical Society, was moderator and panel participants were Drs. Fred Long, health officer of the Peoria City and Peoria County Board of Health; Felix A. Tornabene, health officer, Northwestern Regional Office, Aurora, and L. L. Fatheree, health officer of the Will County Health Department, Joliet.

## MACON

**Society News.**—"Re-Evaluation of Common Uterine Operations" was the title of a talk before the Macon County Medical Society, recently, by Dr. Stuart Abel, assistant professor of obstetrics and gynecology, Northwestern University Medical School.

**Personal.**—Morton Crew, M.D., Decatur, recently passed his final examinations for the American Board of Pediatrics.

## VERMILION

**Annual Play-Day Meeting.**—The June 10 meeting of the Vermilion County Medical Society was devoted to an afternoon session of golf at the Hubbard Trail Country Club, Rossville; a social hour and dinner occupied the evening session. The May 4 meeting of the society was held at the Veterans' Administration in Danville. Louis R. Limarzi, associate professor of medicine, University of Illinois, College of Medicine, gave the evening presentation on hematology.

## WINNEBAGO

**Innovations for Care of Patients.**—The much discussed and long delayed change in the medical care of the patients in the Rockford Township Hospital is going into effect on Monday, June 7, 1954. To familiarize all of the society with the important changes, the following innovations are noted.

1. All patients in the Township Hospital, with the exception of those in the contagion ward, will be the responsibility of the active staff of the hospital.

2. The active staff is composed of the Vice-President of the County Society, a chief of medicine and a chief of surgery, appointed for one year, and various members of the society, appointed to serve a two months tour of duty.

All members of the County Medical Society are eligible for membership on the staff of the Township Hospital and quoting from the Constitution of the Hospital "An obligation of society membership is participation in the care of the patients of this hos-

pital". The first staff has been selected, and are now formulating their policies. As the need arises to replace the staff, society members contacted for choice of service, and when they will be available for their tour of duty.

This plan may have defects which can be corrected when a better solution is apparent. It is the one plan that has been endorsed by the majority of the Society who have been interested in the work at the Township Hospital, and it has been approved by the County Medical Society.

## GENERAL

**Governor's Conference.**—People from many sections of the state are participating in plans for the 11th Governor's Conference On Exceptional Children which will be held in Peoria, Friday, September 24, 1954. This state-wide conference, sponsored by the Illinois Commission for Handicapped Children, is heading up under the theme of "The Ounce of Prevention". Experts from a number of fields serving children will take part in the program which will include sectional meetings and work-shops with focus on prevention-planning for handicapped young people.

Among the sectional meetings being arranged are: The work of Public Health In Preventing Handicapping Conditions in Children; Prevention of Emotional Scars — the Role of Social Service; Use of Healthy Group Experience to Prevent Maladjustment.

The conference is open to all persons concerned with physically or mentally handicapped children, parents, professional workers, and interested citizens. There are no registration fees.

The completed program with the speakers and discussion leaders will be announced soon, said Miss Jane Bull, Executive Director of the Commission for Handicapped Children. Inquiries concerning the conference, she said, may be directed to the Commission, at 160 North LaSalle Street, Chicago 1, Illinois.

The Commission for Handicapped Children is a state agency with responsibility to study the needs of both the physically and the mentally handicapped children in Illinois, and to promote a program of adequate services for them.

**Co-Chairman Named.**—Mrs. Margaret B. Cowdin, of Springfield, has been appointed co-chairman of the Illinois State-Wide Public Health Committee by Dr. Roland R. Cross, director of the state Department of Public Health, with the approval of Governor William G. Stratton.

Mrs. Cowdin, a worker in the field of public health for many years, has held the positions of executive secretary of the State-wide Public Health Committee and chief of the Bureau of Health Education in the state health department. She has been active with women's civic and cultural groups throughout the state and a supporter of the local health services movement in Illinois. Mrs. Cowdin is the wife of a Springfield physician, Dr. Fred P. Cowdin.

Benjamin Wham, Chicago attorney, chairman of the committee for more than 10 years, plans to continue in that capacity.

Harold K. Fuller, of Springfield, was recently appointed executive secretary.

The committee, which has been active in promotion and establishment of local health departments in 27 of the state's 102 counties through local affiliated public health committees, has members in each county of the state and, according to Chairman Wham, will continue to assist these members in expanding their local health services.

### DEATHS

PAUL C. BOOMER, retired, Chicago, who graduated at Northwestern University Medical School in 1892, died February 4, aged 85.

CLINTON FRANKLIN COSTENBADER, retired, Chicago, who graduated at the University of Virginia Department of Medicine, Charlottesville, in 1910, died May 16, aged 67. He was a member of the staff of Hines General Hospital and affiliated with the United States Public Health Service.

ELWOOD HUNTER COX, Mount Pulaski, who graduated at the University of Illinois College of Medicine in 1932, died February 26, aged 45, of cerebral hemorrhage and hypertension. He was a member of the staffs of Evangelical Deaconess and St. Clara's Hospitals in Decatur, and a member of the Illinois State Medical Society.

THOMAS HARRY CULHANE, Rockford, who graduated at the Chicago Medical School in 1935, died April 17. He was a Major and Flight Surgeon in the Ninth Air Force and became ill on his way to Guam where he was to set up a medical clinic. He was a member of the Illinois State Medical Society.

FRANK DENEEN, Bloomington, who graduated at Northwestern University Medical School in 1915, died April 12, aged 63, of acute myocardial infarction and coronary occlusion. He was a member of the Illinois State Medical Society and of the Endocrine Society; formerly vice-president of the Illinois Heart Association, and on the staffs of St. Joseph's and Mennonite Hospitals, Bloomington.

EGON W. FISCHMANN, Chicago, who graduated at Rush Medical College in 1906, died June 13, aged 69. He was professor of obstetrics and gynecology at the Chicago Medical School, attending gynecologist at Cook County Hospital, and a member of the Illinois State Medical Society.

HARRY J. FREMMEL, retired, Chicago, who graduated at the College of Physicians and Surgeons of Chicago, School of Medicine of the University of Illinois, in 1912, died June 1, aged 71. He was affiliated with the Municipal Tuberculosis Sanitarium for 20 years.

CHARLES J. GORR, Chicago, who graduated at Bennett Medical College in 1899, died June 9, aged 80. He had practiced medicine on Chicago's west side over fifty years.

HAROLD HAMMETT, Ohio, who graduated at the College of Physicians and Surgeons, School of Medicine of the University of Illinois, in 1911, died March 21, aged 78, of teratoma of the cervical spine.

RALPH OTIS PETERSON, Chicago, who graduated at the University of Illinois College of Medicine in 1928, died April 25, aged 52, of coronary thrombosis and hypertensive heart disease. He was a member of the Illinois State Medical Society and on the staff of Bethany Methodist Hospital.

SIDNEY A. PORTIS, Chicago, who graduated at Rush Medical College in 1919, died May 23, aged 59. He was clinical associate professor of Medicine (Rush) at the University of Illinois College of Medicine and a member of the Illinois State Medical Society.

ESTHER RAHN, Chicago, who graduated at the Chicago Medical School in 1928, died June 14, aged 56. She was a member of the Illinois State Medical Society.

EDWARD J. ROSS, Oak Park, who graduated at the Chicago College of Medicine and Surgery in 1913, died June 9, aged 62.

CHARLES N. STEPHENS, Industry, who graduated at the Chicago Homeopathic Medical College in 1896, died February 28, aged 81, of a spinal injury received in a fall. He was a member of the Illinois State Medical Society.

JEROME F. STRAUSS, retired, Chicago, who graduated at Rush Medical College in 1897, died May 24, aged 65. He was a member of the Illinois State Medical Society and a specialist certified by the American Board of Otolaryngology.

WILLIAM J. WATERS, Chicago, who graduated at Bennett Medical College in 1914, died June 6, aged 74. He was a member of the staff of Provident Hospital.

EARL C. WHITE, West Brooklyn, who graduated at Keokuk Medical College, Iowa, in 1894, died March 21, aged 83, of meningitis. He was formerly a member of the staff of the Dixon State Hospital.

# HOUSE OF DELEGATES



The first meeting of the House of Delegates of the Illinois State Medical Society was held in the Hotel Sherman, Chicago, on Tuesday, May 18, 1953.

The meeting was called to order at 9:20 A.M. by the President, Willis I. Lewis, Herrin.

**THE PRESIDENT:** As your President I want to report that I am very happy to see such a good attendance and to thank you for your help during the past year. We will proceed without ado to our business. I would like to call attention to this little pamphlet received by all the delegates, especially to Page 5 calling attention to the necessity of giving your name when you wish the floor, so that the stenographer will have it for the record.

The first order of business is the report of the Credentials Committee, Dr. Harlan English, Danville, Chairman.

**DR. HARLAN ENGLISH, Danville:** Mr. President: The Credentials Committee has certified 137 delegates and officers, and for this session I would move that they constitute the voting strength as checked against the attendance slips which have just been signed. (Motion seconded by Dr. Mather Pfeiffer, Alton, and carried).

**THE PRESIDENT:** The next order of business is the roll call by the Secretary. The attendance slips which have been collected will constitute the official roll call.

The Secretary, Dr. Harold M. Camp, has an important guest to introduce.

**THE SECRETARY:** We have a gentleman here representing this Hotel and I think it is important that you get acquainted with this man if you have any grievances or any compliments. It is my pleasure to introduce Mr. Earl Benedict, Convention Manager of the Hotel Sherman.

**MR. BENEDICT:** It is a pleasure to see you fel-

lows again. If you ring my phone I will answer you. Seriously, we are glad you are back. Mr. President, on behalf of the Sherman Hotel I want to present this gavel to you. You can take it back home with you. I hope you will not need to use it on this group.

**THE PRESIDENT:** Thank you Mr. Benedict. I appreciate this very much. I thank you for all the favors extended to me and to the group during the year when we were your guests.

We have another very distinguished man as our guest, also a member of our Illinois State Medical Society. He has a very important position in organized medicine. It is my pleasure to present to you Dr. George Lull, who is the Secretary and General Manager of the American Medical Association.

**DR. LULL:** Dr. Lewis and members of the House: I came down here to listen, not to talk. I want to say that I wish our hotel situation in San Francisco was as good as it appears here. I just got a call from San Francisco a week ago yesterday, saying, "all our rooms are gone and I have not heard from 40 delegates, what are you going to do about it? I said, "I am not going to do anything, what are you going to do?" Seriously, I know the situation is bad in San Francisco but we are trying to do the best we can about it.

There is one thing I would like to request from the members of the House. If any of you get time, and you probably will not because I know how busy our own delegates are, but if you get any time, will you please come up to 535 N. Dearborn Street and let us show you what we have. Remember it is your headquarters. As I have said before, a great many members do not realize that they are stockholders in a million dollar corporation. There are 140,000 stockholders in this corporation and that means that you have big business. We have guides there and we will be delighted to see you, Thank you very much.

THE PRESIDENT: Thank you Dr. Lull, we are very glad to have you here.

The next order of business is the approval of minutes of 1953 annual meetings as published in the July and August issues of the Illinois Medical Journal.

DR. MATHER PFEIFFENBERGER, Alton: I so move. (Motion seconded by Dr. C. Paul White, Kewanee, and carried).

THE PRESIDENT: I would ask Dr. Joseph T. O'Neill, Ottawa, and Dr. William Scanlan, La Salle, to escort Dr. George Allen Dicus to the platform.

Members of the House, I am presenting Dr. George Allen Dicus, the outstanding general practitioner of the State of Illinois for 1954. Dr. Dicus is a true representative of the general practitioner and of the family doctor. Dr. Dicus was born in 1863 in Moscow, Ohio, the son of William and Abigail Dicus. At the age of 14 months they moved to Illinois where Dr. Dicus has remained ever since. Dr. Dicus is now 90 years old. He had a tough time obtaining his medical education. At the age of 17 he embarked on this career; however, it was not until 1887 that he got started in medical school, at Rush Medical College. He graduated in 1890. He joined his brother who was in practice in Streator, Illinois, but decided he wanted more education and went to Europe and there trained under some of the eminent pathologists and surgeons. Returning during the year he settled in Streator and has remained there ever since, having practiced medicine for 64 years. His wife died in 1925 as the result of an automobile accident. He has a family consisting of one daughter, Miss Louise, who lives with him and cares for him, and five sons.

Dr. Dicus has practiced these 64 years and has cared for his patients as a true family doctor would care for them. He has always held high the esteem of the people in his community and has been an outstanding general practitioner.

It is with great pleasure, Dr. Dicus, that I present to you this certificate. This certificate reads: "This is to certify that George Allen Dicus has been selected as the Outstanding General Practitioner of Illinois for 1954 by virtue of his years of ministrations to a large host of patients as family physician. Therefore, in recognition of services to his patients and to this organization, we the officers of the Illinois State Medical Society confer upon him this Award." Signed by the President, the Chairman of the Council, F. Lee Stone, and the Secretary. It is a great pleasure to present this to you, Dr. Dicus.

DR. DICUS: Dr. Willis I. Lewis, President of the Illinois State Medical Society, and Members of the House of Delegates: In accepting this certificate of award words fail to express my gratitude and appreciation for all that it means to me. It brings to me so vividly the changes and progress in medicine in the past 64 years. In 1890, to obtain the advantages of more clinical work I went to the University of Berlin

for a year. While there I attended the Tenth International Medical Congress. At a dinner given by the city of Berlin for 5,000 pathologists, the great pathologist, Virchow, was honored by placing him on their upheld hands over their heads.

In 1891 on returning to the United States I attended the American Medical Association meeting in Washington. Within a decade, many clinical changes took place. In 1890, typhoid fever was common, smallpox and diphtheria not uncommon. These diseases are uncommon today due to the desire of the profession then as now to eliminate disease.

Among the many changes are the remuneration for services. Office calls then were fifty cents, home visits one dollar. The means of transportation have improved, no more walking in the mud or driving a horse and buggy. Since 1890, I have found benefits and pleasure in attending the medical meetings of the county, the district, the State and the American Medical Association. Often I have attended meetings of the House of Delegates though not a member and found pleasure in doing so. Doctors today are afforded a glorious opportunity for postgraduate work in many groups and meetings available today, especially the Illinois State Medical Society. I recall with pleasure accepting on April 8, 1940 the Fifty Year button presented to me by the Councilor of our District, the late Dr. Edgar C. Cook of Mendota, in behalf of the Illinois State Medical Society. Last November 9, Dr. Joseph T. O'Neill of Ottawa, Councilor of our District, called at my home at the request of Dr. Harold M. Camp, the Secretary, to inform me of the action of the secret group on November 8, in selecting me as the Doctor of the Year for 1954. I was completely unprepared for this shock but I recuperated enough to be present today. To the Illinois State Medical Society and to each and every one of my fellow associates who had to do with bringing about this happy experience to me, I say thank you.

THE PRESIDENT: Thank you very much Dr. Dicus. From all reports I understand he has well recuperated. I understand he carries on practice in the office but does not do surgery any more.

The next order of business is the appointment of Reference Committees. These are listed in the Handbook, but I shall read them.

1. **Committee on Credentials:** Harlan English, Danville, Chairman, Charles Allison, Kankakee, Fred H. Muller, Chicago, and Jack Williams, Chicago.

2. **Committee on Attendance:** Caesar Portes, Chicago, chairman, Harold W. Miller, Chicago, J. A. Petrazio, Ava, and Henry Sandeen, Woodstock. Alternates: Charles Roth, Chicago, and J. K. Rosson, Tammam.

3. **Committee on Reports of Officers**—to receive and report on the reports of the President, President-Elect, the Secretary-Treasurer, and the Committee on Scientific Work. (For your information, this report is not published, but the Reference Com-

mittee should review the meeting of the State Society, comment on the scientific programs, the technical and scientific exhibits, movies, etc., and make suggestions for the improvement of future meetings.): Tom Kirkwood, Lawrenceville, Chairman, Norman L. Sheehe, Rockford, O. W. Rest, Chicago, and S. M. Goldberger, Chicago. Alternates: Charles Ahlm, West Frankfort, and Charles Ryan, Chicago. This committee will meet in Room 113 at 10:00 A. M. Wednesday morning, May 19.

**4. Committees on Reports of Councilors.**—to receive and report on the reports of the Chairman of the Council, the Councilors of the Eleven Councilor Districts, the Councilor at Large: G. Henry Mundt, Chicago, Chairman, Robert H. Hayes, Chicago, Darrell H. Trumpe, Springfield, and N. A. Thompson, Eldorado. Alternates: John C. Wall, Chicago, and Peter Rumore, Effingham. This Committee will meet in Room 111 at 10:00 A. M., Wednesday, May 19.

**5. Committee on Reports of Standing Committees**—to receive and report on the reports of Committee on Medical Service and Public Relations, Medico-Legal Committee, Committee on Archives, Committee on Medical Education and Hospitals, Committee on Medical Benevolence, Committee on Medical Testimony, and Grievance Committee: C. Paul White, Kewanee, Chairman, William Whiting, Dongola, Edward Helfers, Chicago, and M. A. Rydelski, Chicago. Alternates: Michael Boley, Chicago, and Andrew Krajec, West Salem. This Committee will meet in Room 105, at 10:00 A. M., Wednesday, May 19.

**6. Committee on Reports of Council Committees "A"**—to receive and report on the reports of Editors of the Illinois Medical Journal, Editorial Board and Journal Committee, Delegates to the American Medical Association, Advisory Committee to the Illinois Public Aid Commission, and Advisory Committee to the Veterans' Administration: John R. Wolff, Chicago, Chairman, Charles Eck, Chicago, E. E. Davis, Avon, and J. C. Ellis, DeKalb. Alternates: John Siedlinski, Chicago, and J. A. Mathis, Pinckneyville. This Committee will meet in Room 110 at 10:00 A.M., Wednesday, May 19.

**7. Committee on Reports of Council Committees "B"**—to receive and report on the reports of Advisory Committee to the Women's Auxiliary, President of the Women's Auxiliary, Advisory Committee to the United Mine Workers, Advisory Committee to Illinois Chapter, American Legion, Advisory Committee to Selective Service, Committee on Blood Banks, and Committee on Cancer Control: J. C. Redington, Galesburg, Chairman, John O. Cletcher, Tuscola, Frank H. Maple, Chicago, and Lorne Mason, Chicago. Alternates: A. J. Weigen, Chicago, and C. O. Absher, Newton. This Committee will meet in Room 108, at 10:00 A.M., Wednesday morning, May 19.

**8. Committee on Reports of Council Committee "C"**—to receive and report on the reports of Committee on Cardiovascular Disease, Constitution and By-Laws (no written report) Crippled Children's Clinic Committee, Committee to Investigate Coroner's Office, Committee on Diabetes, Educational Committee, Ethical Relations Committee: Percy E. Hopkins, Chairman, Chicago, Fred L. Glenn, Chicago, Walter Baer, Peoria, and W. H. Schoengerdt, Champaign. Alternates: Casper Epsteen, Chicago, and R. E. Dunlevy, Pekin. This Committee will meet in Room 113 at 2:00 P.M., Wednesday, May 19.

**9. Committee on Reports of Council Committees "D"**—to receive and report on the reports of The Fifty Year Club Committee, Committee on Industrial Health, Interprofessional Relations Committee, Maternal Welfare Committee, Medical Economics Committee, Committee on Medical History: George B. Callahan, Waukegan, Chairman, John E. Bohan, Alexis, H. L. Wallin, Chicago, and James H. Hutton, Chicago. Alternates: Paul Blackburn, Chicago, and J. H. Langstaff, Fairbury. This Committee will meet in Room 110 at 3:00 P.M., Wednesday, May 19.

**10. Committee on Reports of Council Committees "E"**—to receive and report on the reports of Committee on Mental Health, Committee on Military Affairs and Emergency Medical Service, Committee on Necrology, Committee on Nutrition, Committee on Nursing, Committee on Physical Medicine and Rehabilitation: Warren W. Furey, Chicago, Chairman, Robert Mustell, Chicago, William Walton, Belleville, and David B. Freeman, Moline. Alternates: M. I. Kaplan, Chicago, and H. K. Moulton, Petersburg. This Committee will meet in Room 108 at 3:00 P.M., Wednesday, May 19.

**11. Committee on Miscellaneous Business**—to receive and report on the reports of the following committees, and also on any other business referred by the President; Committee on Post-graduate Education, Committee on Rural Medical Service, Committee on Scientific Service, Committee on Tuberculosis Control, Committee on Voluntary Prepayment Plans, Liaison Committee on Medical Education: Paul A. Dailey, Carrollton, Chairman, Russell Jensen, Monmouth, Wright Adams, Chicago, Karl L. Vehe, Chicago. Alternates: A. J. Linowiecki, Chicago, and J. J. Grandone, Gillespie. This Committee will meet in Room 105 at 3:00 P. M., Wednesday, May 19.

**THE PRESIDENT:** The next order of business will be the consideration of Annual Reports as published in the HANDBOOK, with supplementary reports as desired.

## ANNUAL REPORTS OF OFFICERS & COMMITTEES

### REPORT OF THE PRESIDENT WILLIS I. LEWIS, HERRIN

In the beginning of my report as President of our fine Illinois State Medical Society, may I express to you, one and all, my sincere appreciation of the honor you have bestowed upon me.

It has been my privilege and pleasure during my year's tenure of office to have travelled extensively throughout the state. It has amounted to approximately 18,000 to 20,000 miles as to distance, and as to time—perhaps one seventh of it has been spent away from home. A small portion of this time was spent in visiting three of our neighboring states, Kentucky, Indiana and Wisconsin. This to me, is good neighborly relations. Our important observation on these out of state trips was how these states stagger the meetings of their House of Delegates so as to have the least possible conflict with their regular scientific sessions. We have in our program planning, kept this in mind, and no doubt in the future will have fewer conflicts than are now evidenced in the 1954 meeting.

In going about the state it has been our observation that the general *esprit de corps* of our profession is good. We find the opposition to the additional \$20.00 of our dues for the American Medical Education Foundation is much less than it was a year ago. This to me is a heartening sign. The Illinois State Medical Society is to be congratulated for spear-heading this movement. I am reliably informed that the Utah State Medical Society is following suit in this per capita support of the Foundation, and other states are considering similar action. We believe in private enterprise in medical education as well as all other phases of the American Way of Life. When government subsidizes, she invariably sets the policies for operation.

One and one-half years ago with the change of administration in Washington, we of medicine developed a feeling of security and complacency about socialistic encroachment. Developments recently have relighted the flame of apprehension. Some of the appointments in Washington, requested legislation, opposition to other legislation, and encroachment of the Veterans Administration on the private practice of medicine are some of the signs of approaching danger.

Your President had the privilege of visiting our headquarters office in Monmouth during the first week of April. It was enlightening and amazing to see how efficiently Dr. Harold Camp and his force executed the work of our Society. Every one of the employees has her job to do and it is done with dispatch.

Doctor Camp's executive assistant, Mrs. Frances Zimmer, directs all the work of the office during his absence. Mrs. Zimmer is most efficient and cordial in maintaining excellent office morale.

Mrs. Jane Swanson has charge of our physician placement service. This function of our Society is doing a marvelous job in getting medical service to our rural areas in Illinois. It has resulted in the location of about 100 physicians in needy areas. This service of

the Society gained national recognition when it was reported in the Journal of the American Medical Association in the October 17, 1953' issue.

The finances of the Society, amounting to approximately \$700,000 per year, clear through the able hands of Mrs. Wanda Ross, bookkeeper and accountant. She also has charge of the maintenance of society membership records.

Mrs. Mary Ward has charge of mailing, stencil files, mimeographing and records. She too does her work quickly and efficiently.

While at the Monmouth office I took advantage of the opportunity to browse through old records of Society proceedings—the oldest being a report of the annual meeting of 1852—102 years ago. This part of my sojourn at the Monmouth office was most interesting. It showed not only progress in scientific medicine, but marked advances in the handling of the meetings and the magnitude of growth in our Society.

In looking over these historical documents, it prompted me to make this recommendation that the present plans for the publication of the second volume of the History of Medicine in Illinois should proceed without delay. In this connection I should like to personally commend Dr. D. J. Davis, Permanent Historian of the Society, and Dr. James H. Hutton and his Committee on Medical History for their continued interest in the development of the mass of historical data thus far accumulated.

It is the considered thinking of your President that an office ownstate should never be abandoned. When the time comes for Doctor Camp to drop out of office (and may a kind Providence allow a lengthy extension), and the office leaves Monmouth, I would think of a permanent establishment of headquarters at Springfield, the seat of our State Government—where we could have our own building. There are definite reasons for this line of planning—one of importance is economics. The building, maintenance and personnel could be had more reasonably. It has been my observation at the national level that most state medical society offices are maintained at each state's respective capitol city.

However, I am not advocating the closing of the Chicago office. This should also be maintained. It would be a recommendation, however, that our present office setup in Chicago be combined in one physical unit. At present the general office of the society is on one floor at 185 North Wabash Avenue, while the Committee on Medical Service and Public Relations is on another. If these were combined, I am sure it should be more economical and would improve the efficiency of our services.

Another means of improving the efficiency of the Society as a whole would be to secure an executive assistant secretary for indoctrination under the supervision of our present secretary, Dr. Harold Camp. Dr. Camp has a wealth of background material, a store of knowledge accumulated through his years of service, which he in turn could impart to anyone fortunate enough to work in cooperation with him in an executive capacity.

This in no wise anticipates anything other than an addition to the present personnel. It is my thought now that this assistant secretary could carry on in the Chicago office and at such time when the necessity arises, he would be able and trained to assume the important work which Dr. Camp has done so efficiently through the years.

The Council, under the leadership of its Chairman, Dr. F. Lee Stone, has functioned very smoothly and efficiently during the past two years—my tenure as President-Elect and as President. The Council carries on all Society business in the interim from one annual meeting to the next. I feel very grateful toward this group of fine men, and I am happy to add them to my list of friends. Sincere thanks to you, Doctor Stone, and to all members of the Council.

I should like to reiterate my suggestion given in my report as President-Elect last year, that at least society officers be brought to our Council meetings in small groups throughout the years. This will familiarize them with the workings of their State Society. This can only result in better intra-society relations, and in the end, cement our great Society into a potent unified organization.

I should like to mention by name chairmen and members of all committees, but time and space will not permit. In a general way, I want to thank and commend all committee personnel. Dr. F. Lee Stone, Chairman of the Council, will give you a report on all general activities.

It appears to me that the Medical Service and Public Relations Committee under the chairmanship of Dr. Percy E. Hopkins, and directed by Mr. James C. Leary, deserves special mention. This Committee is important from many angles—especially from the standpoint of the public. This is a two sided proposition. Doctors should and must maintain good liaison with the public. The Committee has compiled and printed a very good manual on public relations. This manual should be in the hands of every member of the Illinois State Medical Society. It would be well that this be done without delay. Every county society secretary should write for a supply adequate for his roster of members. Good public relations stem from the office of every family physician.

The Postgraduate Education Committee, under the chairmanship of Dr. George A. Hellmuth, has done a commendable job this past year. The conferences have been well attended and the programs have been excellent. It has been our observation that the panel type program has been very well received. I want to commend Doctor Hellmuth and his Committee, also to extend my thanks personally as President, to each and every physician who participated in the postgraduate conference programs.

The Woman's Auxiliary to our State Society under the leadership of Mrs. Henry Christiansen as President, has carried on in its traditionally effective manner. This organization is the Society's most effective factor for building up and maintaining good public relations. These ladies are very helpful in encouraging their husbands,

the physicians, to participate in community or civic affairs. They are quite helpful also in compiling medical history data. One of their most commendable activities has been the medical benevolence fund drives. We salute and thank you most sincerely, Ladies of the Auxiliary. And with this salute, I would urge that the Society continue its wholehearted support of the Auxiliary in its work for the good of the profession.

Another observation of mine while traveling throughout our great state of Illinois was the diversification of its industries and the stable condition of our economy. In this respect I am sure we rank well above the average.

I also was impressed with the good type of medical care and to note that the need for rural medical service is fairly well supplied. However, there are spotty areas in the state where physicians are still needed. This need is rapidly being filled by our placement service.

Another important factor in the improvement of our rural medical services is that all areas are being supplied with good hospitals. Over \$60,000,000 have been spent in the construction of new hospitals throughout this state under the Hill-Burton and state building programs.

The Hill-Burton program of course, is concerned mostly with the construction of general medical and surgical hospitals, whereas the state program during the past few years has been concerned primarily with the construction of tuberculosis sanatoria. A large percentage of these new hospitals has been built in the southern half of the state where the need has been more urgent. Where there are good hospitals, good and adequate medical personnel is attracted to the area.

In conclusion I should like to leave a few personal thoughts with my Society. In the beginning, I studied medicine because I had a burning desire to be a doctor. Though my medical education was obtained by way of the "school of hard knocks" in that much of my time was spent working in order to subsist, for this I have no regrets. My professional life has been spent serving humanity, as was my desire in the beginning. It has been my good fortune to belong to one of the best state medical societies in our country. I have been blessed with many friends, both in and out of my profession. For all these things, I am most grateful to a kind Providence, and to all my friends in the Society who have accorded me the honor of being the 104th President. It is my sincere desire that our Society go forward and attain even greater success and remain a vigilant outstanding unit of organized medicine throughout the years to come.

Respectfully submitted, WILLIS I. LEWIS, M. D.,  
*President.*

#### **REPORT OF THE PRESIDENT-ELECT ARKELL M. VAUGHN, CHICAGO**

Your president-elect during his indoctrination period has stood by ready to help your president, and substitute for him when he deemed it necessary.

My first official act as president-elect was to attend a

testimonial dinner given in honor of Dr. Willis I. Lewis by his colleagues in southern Illinois at the West Frankfort Country Club. The large attendance bespoke the esteem and respect in which Dr. Lewis is held in his community.

September 9 I attended the House of Delegates meeting of the Michigan State Medical Society at Grand Rapids. Their House of Delegates meets two days prior to the Annual Meeting. This enables the delegates to attend the scientific sessions. They have a speaker and a vice speaker of the House of Delegates. I hope some day Illinois can have such an arrangement.

I attended the Annual Meeting of the American Medical Association in New York City, New York, and the interim session at St. Louis.

The Blue Shield Medical Care Plans held a special meeting, which I attended, in January 1954, at the Palmer House in Chicago. There was much valuable discussion concerning medical care insurance at this meeting.

I have attended and enjoyed all the meetings of the Interprofessional Council. This Council is composed of representatives of six professions dealing with the healing arts — medicine, pharmacy, dentistry, optometry, veterinary medicine and chiropody. Through this medium many advantages can be obtained for the benefit of both the public and the professions involved. Parenthetically I heard many expressions of gratification and appreciation for the contributions our Medical Society has made both through our delegates to the Interprofessional Council and the time and experience given by Mr. John W. Neal and Mr. James C. Leary.

I have attended all the meetings of the Council, the Executive Committee, and Editorial Board and have attended many other committee meetings during the past year.

I am very grateful for the honor which the State Society has conferred upon me. With the assistance of your Secretary, the Chairman of the Council, the chairmen and members of the numerous committees, I shall do my utmost to serve you as well and as faithfully in the ensuing year as those who have preceded me.

Respectfully submitted, ARKELL M. VAUGHN,  
M. D., *President-Elect*.

#### **REPORT OF THE SECRETARY-TREASURER HAROLD M. CAMP, MONMOUTH**

In presenting this thirtieth annual report as secretary of the Illinois State Medical Society, I should like to make a few brief comments on the conditions of thirty years ago as compared with our present day problems. In 1924 the membership of this Society was only slightly more than one-half of the present number on the membership list. We did not have many of the present day problems. We had only recently seen the end of World War I, "the war to end wars," as many of you will recall. We had seen Illinois as one of the few states which did not approve the operation of the Sheppard-Towner Act, and the statistics proved conclusively that this state did not suffer in any way

through this action on the part of our State legislature.

Dr. Charles J. Whalen, for many years editor of the Illinois Medical Journal, introduced the first resolution in the A. M. A. House of Delegates which urged that the House go on record as opposing government inroads in medical care. He had been chairman of a state medical society "Committee on State Medicine" for several years, and in his annual report before the House of Delegates of this Society, he referred to a number of bills which had been introduced in several states, which if approved, would have given medical care to certain groups at the expense of the residents of the individual states.

The A. M. A. House, the first year Whalen's resolution was introduced, did not believe there were any efforts in Washington to develop any type of medical plan under government supervision, and the resolution was not approved. However, within a short time another similar resolution was approved, and the A. M. A. House did go on record as opposing any form of state medicine.

Then not long afterwards, we were in the midst of an economic depression, which affected the medical profession as it did all other professions and individuals in this country. The annual dues of the Society were \$5.00 per member, and this entitled the member to a subscription to the Illinois Medical Journal. In 1935 we saw the development of the Social Security Act with its myriads of problems affecting the practice of medicine.

During the past thirty years we have seen more advance in medicine in all of its branches than had been made in any similar period in history. One needs only to compare the programs for the annual meetings in the early 1920's with those for recent years to convince himself of this fact.

At the annual meetings of thirty years ago, we had no published handbook with reports of officers and committees as we do today. The first meeting of the House was held on Tuesday evening, and each annual report had to be read in full by the officers or chairman of the committee reporting. It was not unusual for this first meeting to be in session until one o'clock in the morning. The second session of the House was held on Thursday. We did not have as many official committees to report in those days—or perhaps the first session of the House might have continued throughout the night.

Today we have seven constitutional committees and about 38 Council committees, all of which must report to this House and/or the Council. Even though we have this large number of committees, there is rarely a month which passes without some group asking for the development of one or more additional committees.

With the many problems confronting the medical profession today, it is doubtful if many of us would care to go back to the conditions of 30 years ago—especially to the methods of that period of treating diseases.

## THE SECRETARIES' CONFERENCE

In most of the state medical societies of this nation, the annual secretaries' conference is scheduled in the interim between annual meetings, and also includes the presidents and the other county society officers. The sessions are usually all day affairs. The officers of our Secretaries' Conference early this year asked the Council for permission to schedule the 1954 meeting either in Springfield or Peoria, preferably on the first Sunday in April. After some deliberation, the Council gave its approval, and the meeting was scheduled for Springfield on April 4.

With only a short time to arrange the program and make other arrangements, the meeting was considered to be a definite success. There were approximately 100 members present; representatives attended from 13 of the 15 branch societies of the Chicago Medical Society, and from about 40 counties outside of Cook. The program went over well; there were a number of interesting exhibits, and the group present voted to ask this House of Delegates and the Council to permit scheduling of a county society officers' conference apart from the annual meeting.

It was stated specifically that this should not be limited to secretaries alone, but all county society officers and all members of the state society desiring to attend should be welcome. With more time to make the arrangements for the meeting next year, it seems quite logical that a much larger attendance can be expected.

Among the exhibits at this Conference was one showing the method of keeping records in the secretary's office in Monmouth—the forms used, how remittances are handled, and the membership cards sent out. Also featured were the various forms available in the secretary's office for component society secretaries. Another portion of the exhibit showed the operation of the Physicians' Placement Service and the forms used to secure the desired information from both the physicians and the communities which believe they need medical personnel.

Quite a number of the bulletins issued by the component societies were available, as well as other releases from the American Medical Association, as well as from several component societies. James C. Leary, Public Relations Director, had copies of the pamphlet, "The Public Relations of County Medical Societies" recently prepared by the Committee on Medical Service and Public Relations of the state society.

## THE 1954 ANNUAL MEETING

One of the most difficult things to schedule at the annual meeting each year are the meetings of the House of Delegates. Realizing that many delegates (and there are more than 200 of them) desire to attend as many scientific sessions as possible during the annual meeting, efforts have been made to take this into consideration when setting the meetings of the House. We note on reviewing programs from many other state societies that a number of them hold the first meeting

of their House on either Sunday or Monday—one or two days prior to the opening of their annual session. This means, of course, that delegates must spend one or two extra days at the meeting.

This year the first meeting of the House has been scheduled for Tuesday morning so that delegates may attend the general assembly session that afternoon. However, it was not possible to change the short meeting of the House on Thursday, or the last meeting on Friday morning. I am sure that the Council will appreciate an expression from this House of Delegates as to its preference in regard to the scheduling of these meetings in the future.

The scientific programs for the annual meeting have been carefully planned, and should appeal to the membership in general. The Committee on Scientific Work, composed of the officers of the various Sections, and the elected Executive Committee, deserve much credit for the fine program they are presenting at this meeting.

The usual array of scientific and commercial exhibits has been scheduled and each of them has been carefully selected. Again we want to call your attention to the fact that each of you should stop at the exhibit booth of every commercial exhibitor, sign registration cards, and help express your appreciation of the participation of these firms at this annual meeting. As usual, a recess period is scheduled for each half day during the meeting to permit the members to view exhibits.

The scientific exhibits arranged by Dr. Coye C. Mason and his committee have been selected carefully and represent many of the newer things in medicine.

They too deserve your careful attention. It is generally recognized at meetings today that the scientific exhibits are of the greatest importance in keeping abreast of the developments of the year. Those of you who have never assembled a scientific exhibit find it difficult to realize the amount of time and work necessary to produce each exhibit—as well as the expense involved.

On Friday afternoon an experimental meeting has been scheduled called "The Kollege of Xperience" for the benefit of the interns and residents in Illinois hospitals. Letters have been sent to nearly 2,000 interns and residents in Illinois urging them to attend this session. Harlan English, as chairman of the Committee on Rural Medical Service, will preside at this meeting. Four speakers have been selected to make talks on some of the problems in medical care. Then a panel has been arranged to permit a question and answer period. The interns and residents have been asked to write out their questions to be submitted to the members of the panel. Brochures from the A. M. A. and from other sources will be available for the group. This should prove to be an interesting experiment which may lead to the establishment of an annual affair.

## PHYSICIANS PLACEMENT SERVICE

During the past year we have received many letters from physicians desiring an Illinois location, and also from many small communities asking us to aid in securing a physician for them. With the many new

hospitals, especially in the southern end of the state, constructed under the Hospital Construction Act, quite a number of physicians have located in these areas. There are many small towns in Illinois, as elsewhere, which are unable to attract physicians. Most of them, however, are near other towns which have resident physicians who can provide the necessary service. Many of these towns have less than 1,000 population, and some are much smaller.

We had a request recently to find a physician to replace a fine elderly man who died a few months ago. He began his practice in the horse and buggy days and maintained a good practice until his terminal illness. We were informed that this would be a desirable location for a capable young physician willing to work. However, the population of the town shown in our directory based on the 1950 census, was 45 inhabitants. There are physicians nearby who serve that territory, and we have no hope of being able to aid the community in procuring a physician.

We had a call recently from the State Editor of one of the Chicago daily papers, asking if it would be possible to find a physician for a southern Illinois town with approximately 800 population. The town has not had a physician since 1945, and the people of the community asked the paper to aid them in every way possible. We told this man that we had been sending out information relative to the town to our entire list of physicians desiring locations. The need of the community had been called to the attention of over 150 physicians on our list. We told the editor that if small towns expect to secure physicians, they must have certain inducements to offer them, such as good schools, good hospitals, etc. to give the physician a good place to work and to raise his family.

After finishing internship, the majority of our young physicians must serve in the medical corps of the armed forces for approximately two years before beginning practice. Naturally after this extensive preparation for their life work, they will look for a location which in their opinion, has the most to offer them. These physicians naturally want to be near modern hospitals, live in modern homes, have good schools, churches and have some recreational facilities available.

This can be done with the proper team work, even in the small towns, provided the people cooperate properly. Following our long distance talk with the newspaper editor, he came to the Chicago office, and we talked at some length on the subject of procuring physicians for small towns. We told him what we thought the community could do to make the town more appealing to a physician. After the discussion he said he planned to go to the town and talk to the people, suggesting that they provide a suitable home and office for the doctor, then place a sum in the bank from which he could draw to help buy furniture for the home, equipment for the office, and if necessary, to make the first payment on a car. This has been done in a number of small Illinois communities during the past year with excellent results.

The Journal of the American Medical Association of October 17, 1953 published an interesting story of the Illinois State Medical Society Physicians Placement Service which we hope all of you have read. Mrs. Jane Swanson, who has been in the Monmouth office for the past 13 years, has been responsible for the operation of this service. She became interested in this work early in the years of World War II, when it was our duty under Procurement and Assignment Service to find additional medical personnel on short notice to go to some place where there was a physician shortage as a result of so many of the younger physicians going into service.

#### INDIVIDUAL LOCATION PROBLEMS

A few months ago we had a letter from the president of a bank in a small Illinois town. We were informed that they had \$10,000.00 in the bank from which a capable physician could draw, all or any part of it, to help him furnish a home, buy necessary office equipment, and perhaps to buy the needed car. All this was available for him at a low rate of interest, and he would be given time to start repaying the loan in accordance with his increasing income from practice. They had a modern home and a good office ready, and it was only a short time until this community had a competent physician.

Another community informed us that they had a house and an office ready for the physician, and he would not have to pay rent for one year—and then only if his income would justify it. They too have a physician.

We had one small town where there were formerly three physicians, and the last one died some two years ago. We tried to assist them in procuring another physician. Although we sent as many as 150 letters to physicians on our list who stated they were seeking locations, we were not able to procure one for them. Then they decided to make their community more attractive, and a physician located there. Last summer on a Sunday, the town had an outdoor reception for the physician and his family. The entire community joined together, brought food, and had a big community dinner for the physician and his family. All of them assured him that he was a part of the community and they would do everything possible to make him and his family feel that they really belonged to the community. This physician is doing well, and everyone is quite happy.

With so many small cross roads towns in Illinois, most of which are not far from larger towns with physicians, it is probably impossible for many of them to attract a physician. We tell them that the young doctor must have a minimum of three years in college or a university getting his pre-medical training. Then he has four years in medical school and a minimum of one year as an intern. By the time the internship is finished the majority of these young physicians must serve in the medical corps of the armed forces. This means that the average physician today when ready to start his practice, has attained the age of 30, and many

are several years older, and have a family to look after.

We believe, as our Physician Placement Service goes on, that this is one of the most important functions of our office. We have been most fortunate in having Mrs. Swanson devoting a major portion of her time to this work. She will have a placement service exhibit in the Ballroom on Friday afternoon when Doctor English presents his "Kollege of Xperience" for the benefit of interns and residents.

During the past year several additional hospitals have been dedicated, most of them new, but a few are enlargements of previously operating hospitals. One of the most notable of the new hospitals is the fine building at Effingham to replace the one which burned some five years ago with such tremendous loss of life. One of the Society's recent postgraduate conferences was held in this new hospital.

#### STUDENT LOAN FUND

The joint loan fund set up by this Society and the Illinois Agricultural Association is now beginning to pay dividends. Started six years ago, we have seen a number of those receiving the loans called into service upon completing their internship. Some of these young physicians are now being separated from service and are going to their home counties to begin their practice. In the near future we expect to see a number of additional young physicians in the rural areas through this function.

During the past year we have seen quite a change in the attitude of people in many communities needing a physician. People are becoming more aware of the fact that to attract a competent physician to the community they must have something to offer, which will appeal to the physician seeking a location. Realizing that they are placed on a competitive basis, they feel they should have something better than other communities in a similar predicament.

#### ALIEN PHYSICIANS

We are having one problem in Illinois because of the rapidly increasing number of physicians who receive a license to practice in this state although they have not acquired citizenship. These alien physicians are not eligible for membership in their county or state medical society, which makes it more difficult for them to get hospital staff appointments. Likewise it is difficult for them to procure malpractice insurance as most companies make society membership mandatory before they will issue a policy.

We have been informed by the Department of Registration and Education that the majority of candidates for licensure examinations recently have been non-citizens. Frequently too, the communities desiring a physician state that they want the physician locating there to be a citizen of the United States. Illinois is one of the few states where citizenship is not a requirement for licensure, which means that this state will continue to get more alien physicians constantly as time goes on.

#### THE SECRETARY'S OFFICE

The clerical force in the secretary's office has not

changed during the past year. Your secretary during the past year was away from the office 130 days. His executive assistant, Frances C. Zimmer, directs activities in the office during his absence. Mrs. Zimmer completed 18 years in the office last January. She prepares the Secretary's Newsletter which goes out monthly to an ever increasing mailing list.

Jane Swanson is on her 13th year and she devotes much of her time to the Physicians Placement Service, sending out many thousands of letters during the year. She has several other duties assigned to her, all of which are meticulously cared for.

Wanda Ross is designated as the accountant, receiving all remittances, crediting individual memberships, issuing all vouchers in payment of bills, and keeping all financial records of the Society in one master ledger. She has given the Society five years of excellent service.

Mary Ward for seven years has been in charge of the power equipment, the mimeograph, addressograph, folding machine, etc. The office has done much work for the Committee on Postgraduate Education. Mrs. Ward sends out letters announcing the meeting to the physicians in the area two weeks before the meeting is held. Then about ten days before the meeting, the official printed program and return postcard goes to the entire list. On the day of the meeting the secretary and usually two assistants attend the session, handle the registration, pass out badges and sell tickets for the dinner. During the year about 13,000 pieces of first class mail go out from the secretary's office for the Postgraduate Conferences.

Each member of this force knows what is expected of her, and when the mail comes in daily, it is easy to designate each letter to the proper assistant. We again desire to thank these capable and interested assistants for their fine cooperation in handling their assigned duties.

#### THE COUNCIL

Your secretary attends all meetings of the Council, and the records show that he has attended all Council meetings for the 30 years he has acted as secretary, and for the two previous years as a member of the Council. For about 16 years he personally took the minutes, but during the past 14 years this function has been assigned to Mrs. Zimmer.

In order that the members of this House of Delegates may know the duties and responsibilities of the Council, we would ask that you read carefully the report of the Chairman of the Council presented in this handbook. Six or seven regular meetings are held in the interim between the annual meetings. These meetings are invariably held on Sunday with a long agenda which requires most of the day for their completion.

It has been the practice in recent months to invite officers of several component societies and branch societies of the C. M. S. to sit in and observe the work of the Council.

#### MEMBERSHIP DATA

During the past fiscal year, there has been an overall increase in the membership, as a comparison of the

totals as shown in our 1953 report with that of April 30, 1954, will show.

Membership as of May 1, 1953 ..... 9,707  
Added during the year:

New members ..... 502  
Reinstatements ..... 112

Total added for year ..... 614

Dropped during the year:

Died ..... 145  
Removals from the state ..... 138  
Resigned ..... 22  
Non-payment of Dues ..... 222  
Expelled ..... 2  
Non-Citizen ..... 7  
Non-Attendance ..... 1

Total Dropped during the year .... 537

Membership as of April 30, 1954 ..... 9,784

In closing this annual report we again desire to thank the many county society secretaries for the fine cooperation that has been so evident in our many dealings with them.

During the past year we have requested many types of service as a result of action on the part of the Council, the A. M. A., or from other sources. The response has been most gratifying. It has been our privilege to visit quite a number of the county societies during the past year, and there has been no apparent lack of interest on the part of the membership. Our records show that we travelled approximately 60,000 miles in our official work during the past year.

Our associations with the other officers, and the Council, have been cordial and we desire to thank them for their assistance and encouragement in our endeavor to fulfill our many duties and responsibilities.

We also desire to pay our respects to Roland R. Cross, Director, Illinois Department of Public Health, who has attended nearly every meeting of the Council. We all appreciate the cordial association of the Director of the State Department and this Society.

## FINANCIAL REPORT OF THE SECRETARY-TREASURER

### RECEIPTS FROM COUNTY SOCIETIES Fiscal Year Ended April 30, 1954

Adams .....	\$ 3,120.00	Crawford .....	585.00
Alexander .....	650.00	DeKalb .....	2,730.00
Bond .....	195.00	DeWitt .....	520.00
Boone .....	715.00	Douglas .....	955.00
Bureau .....	1,690.00	DuPage .....	9,345.00
Carroll .....	585.00	Edgar .....	910.00
Cass .....	1,560.00	Edwards .....	195.00
Champaign ....	7,345.00	Effingham ....	1,040.00
Chicago Medical		Fayette .....	780.00
Society .....	319,820.00	Ford .....	975.00
Christian .....	1,300.00	Franklin .....	1,722.50
Clark .....	455.00	Fulton .....	1,430.00
Clay .....	780.00	Gallatin .....	260.00
Clinton .....	780.00	Greene .....	585.00
Coles-Cumber-		Hancock .....	325.00
land .....	2,567.50	Hardin .....	.00

Henderson ....	.00	Morgan .....	910.00
Henry .....	2,222.50	Moultrie .....	325.00
Iroquois .....	97.50	Ogle .....	780.00
Jackson .....	1,300.00	Peoria .....	12,900.00
Jasper .....	195.00	Perry .....	1,040.00
Jefferson-Hamil-		Piatt .....	520.00
ton .....	3,297.50	Pike-Calhoun ..	520.00
Jersey .....	325.00	Pope .....	.00
JoDavieess ....	780.00	Pulaski .....	260.00
Johnson .....	195.00	Randolph .....	910.00
Kane .....	12,285.00	Richland .....	870.00
Kankakee .....	5,070.00	Rock Island ..	7,117.50
Knox .....	3,275.00	St. Clair .....	7,902.50
Lake .....	16,445.00	Saline .....	1,495.00
LaSalle .....	9,645.00	Sangamon .....	10,205.00
Lawrence .....	690.00	Schuyler .....	325.00
Lee .....	1,592.50	Shelby .....	877.50
Livingston ....	2,047.50	Stephenson ....	2,340.00
Logan .....	1,625.00	Tazewell .....	455.00
McDonough ...	390.00	Union .....	747.50
McHenry .....	4,225.00	Vermilion .....	9,555.00
McLean .....	5,167.50	Wabash .....	747.50
Macon .....	11,310.00	Warren .....	910.00
Macoupin .....	3,087.50	Washington ...	487.50
Madison .....	7,520.00	Wayne .....	585.00
Marion .....	1,950.00	White .....	682.50
Mason .....	220.00	Whiteside .....	4,225.00
Massac .....	390.00	Will-Grundy ..	260.00
Menard .....	.00	Williamson ...	1,930.00
Mercer .....	455.00	Winnebago ....	14,150.00
Monroe .....	390.00	Woodford .....	585.00
Montgomery ..	1,072.50		

Total .....\$545,802.50

General Fund .....	151,879.75
Benevolence Fund .....	16,940.25
Educational Fund .....	167,270.00
A. M. A. Dues .....	209,712.50

Total .....\$545,802.50

## RECEIPTS AND PAYMENTS Fiscal Year Ended April 30, 1954

### RECEIPTS

#### Component Societies:

General Fund .....	\$151,879.75
Benevolence Fund .....	16,940.25
Educational Fund .....	167,270.00
American Medical Association	
Dues .....	209,712.50
Subscriptions—Journal .....	442.63
Advertising—Journal .....	84,765.16
Exhibits—State Meeting, 1953 .	\$ 2,957.50
Exhibits—State Meeting, 1954 .	9,280.00
Interest on Government Bonds .....	2,125.00
American Medical Association	
Collection Service .....	2,066.59
Advances for Postgraduate Surveys:	
United Cerebral Palsy	
Association .....	\$ 800.00

Chicago Heart Association ..	800.00	1,600.00
Refunds and Miscellaneous Receipts .....	147.63	
Total Receipts .....	\$649,187.01	
Cash Balance, May 1, 1953 .....	147,459.71	
Total .....	\$796,646.72	

#### PAYMENTS

Secretary's Office Expense .....	\$ 33,734.92	
Council Expense .....	16,684.58	
American Medical Association Meetings Expense .....	6,861.63	
State Meeting Expense .....	19,787.26	
Journal Expense .....	71,391.40	
Educational Committee Expense .....	22,460.34	
State Fair Exhibit .....	1,010.77	
Chicago Medical Society—Services .....	654.13	
Committee Expenses:		
Advisory—I. P. A. C. ....	\$ 229.25	
Advisory—United Mine Workers .....	186.44	
Archives and Medical History .....	1,213.70	
Cardiovascular .....	147.36	
Diabetes .....	107.03	
Ethical Relations .....	337.41	
Fifty Year Club .....	949.38	
Gamma Globulin .....	26.88	
Grievance .....	69.02	
Industrial Health .....	570.89	
Interprofessional Relations ..	219.34	
Investigate Coroner's Office ..	55.83	
Liaison Committee—		
American Legion .....	267.02	
Liaison Committee on		
Medical Education .....	124.00	
Maternal Welfare .....	571.75	
Medical Service and		
Public Relations .....	29,484.93	
Medical Testimony .....	24.15	
Medico-Legal .....	7.50	
Mental Hygiene .....	22.95	
Military Affairs and Emergency		
Medical Service .....	97.31	
Nursing .....	112.13	
Nutrition .....	228.96	
Postgraduate .....	4,645.43	
Rural Medical Service .....	10,362.65	
Secretary's Conference .....	898.55	
Scientific Service .....	523.33	
Tuberculosis .....	88.20	
Woman's Auxiliary .....	1,572.01	53,143.40
Social Security Taxes .....	599.62	
State Unemployment Insurance .....	76.72	
Federal Unemployment Insurance .....	88.42	
Transfers:		
Benevolence Fund .....	\$ 16,940.25	
Educational Fund .....	167,270.00	

A. M. A. Dues .....	209,712.50	393,922.75
Total Payments .....	\$620,415.94	
Cash Balance, April 30, 1954 .....	176,230.78	
Total .....	\$796,646.72	

Respectfully submitted, HAROLD M. CAMP,  
M. D., *Secretary-Treasurer.*

FRED N. SETTERDAHL

CERTIFIED PUBLIC ACCOUNTANT

224 Robinson Building Rock Island, Illinois

May 3, 1954

To the Members of The House of Delegates:  
Illinois State Medical Society:

#### CERTIFICATE OF AUDIT

We have audited the following accounts of your Society for the fiscal year ended April 30, 1954:

Secretary's Office—Dr. Harold M. Camp, Secretary  
Journal Office—Mr. L. E. Malley, Manager

Educational Committee—Miss Ann Fox, Secretary  
Benevolence Fund—Dr. Harold M. Camp, Secretary

Dues received from Component Societies have been verified with duplicate receipts, the master ledger cards of each Component Society, and were compared with the Secretary's report.

Amounts received for the Benevolence Fund, A. M. A. Dues, and Educational Fund have been transferred or remitted to the respective funds.

Receipts for Journal Advertising have been verified with the records of the Manager, who receives and remits same to your Secretary.

Interest received on the U. S. Government Bonds has been compared with interest due on the bonds. Other receipts, consisting of Exhibit Rentals, Journal Subscriptions, A. M. A. Collection Service Fees, etc., have been taken into account as recorded.

Payments were made by check and were supported by approved vouchers, orders, etc.

The cash balances were reconciled with the statements of the depository banks.

Investment of your Society consist of U. S. Savings Bonds, Series G, with a par value of \$90,000.00, and 31 and 70-100 shares of common stock of the Chicago and Northwestern Railway Company. These shares were issued in lieu of bonds formerly held. These securities, as well as those belonging to the Benevolence Fund, were inspected by us.

#### BENEVOLENCE FUND:

As of April 30, 1954, the Society had a cash deposit of \$44,158.63 and U. S. Government Bonds, par value \$140,000.00, in this Fund.

The accounts of the various departments have been well kept and, in our opinion, your Secretary's Financial Report presents the cash transactions for the year.

The Council will be furnished with a detailed audit report, which agrees in totals with your Secretary's Report.

Respectfully submitted, FRED N. SETTERDAHL,  
*Certified Public Accountant.*

# REPORT OF THE CHAIRMAN OF THE COUNCIL F. LEE STONE, CHICAGO

As Chairman of the Council of the Illinois State Medical Society, it gives me great pleasure to present my report for my second term in office.

However, I first wish to report several important matters of business, which were not included in my previous report as Chairman of the Council, which was printed in the Hand Book of the Society for the 1953 Annual Meeting.

First, the Council meeting of April 26, 1953. At this meeting several matters of business were taken up which should be included in this report.

Also on Saturday, April 25, 1953, the afternoon before the Council meeting, the IPAC reported on the problems of this committee. Among the complaints was one that the rank and file of doctors participating, did not like the present allowances for drugs. This matter, in a discussion by the committee, was thought to belong to the local chairman of the county in which the complaint arose and was so decided.

The main theme of the policy committee, immediately after the IPAC meeting, was a discussion of ways and means to expedite the Council meetings by reducing the number of committee reports, as well as shortening some. It was also brought up that the number of committees be reduced and a request to outline the function of each committee; the aim being to reduce the length of the various committee reports.

The Council meeting was well attended on Sunday, April 26, 1953. Dr. J. L. Reichert was absent, being in Boston attending a meeting of the National Pediatric Society.

President Sweeney gave a report on the gamma globulin situation, reporting for the committee composed of Drs. Reichert, Lewis and himself. This being the beginning of gamma globulin publicity campaign to enlighten the doctors of the state as well as the public. Also on material sent out by the Health Department publication in local papers as well as the Illinois Medical Journal; the idea being to spread all possible information regarding G. G. to the public and medical profession.

Dr. Harold Camp reported on his office. He stated that Mrs. Frances Zimmer has started her 19th year; Jane Swanson her 13th year, Mary Ward her 8th and Wanda Ross her 5th year. Dr. Camp also reported that in going back over the old records he finds that the Council of the Illinois State Medical Society is actually 50 years old. Another interesting discovery was an action taken by the Council in 1916, when Dr. H. G. Ohls, managing editor of the Journal for 30 years, was authorized to employ a part time stenographer. His daughter, Kathryn Ohls (Mrs. Kathryn Simmons) was employed at that time. This makes her the oldest employee of the Society in years of service. Mrs. Simmons is in the Chicago office at 185 North Wabash Avenue.

Again it was emphasized that the Council meetings should be shortened. Numerous ways to do this were

presented. Presenting the various committee reports at less frequent times; shortening of councilor's reports and if any councilor should have a report that needed more time, this report might be sent to the Monmouth office to be mimeographed and then sent to all councilors in advance.

The last committee meeting before the annual meeting was held on April 28th, the Journal and Editorial Board getting together at the Hotel Sherman with nearly all members present.

The cover color was discussed and red was finally adopted as the color most suited and to be used each month until a change may be ordered.

The Annual Meeting in May 1953 opened Tuesday, May 19th with the registration increasing each day, until finally a total of 3,644 was reached; divided as follows:

Physicians .....	1,833
Students and Interns .....	465
Guests .....	466
Auxiliary .....	309
Commercial Exhibitors .....	491

At this meeting Dr. Leo P. A. Sweeney introduced the new President, Dr. Willis I. Lewis and Dr. Lewis in turn introduced the President-Elect, Arkell M. Vaughn.

The Secretary's News Letter of June, 1953 following the A. M. A. meeting of June in New York City, contained many interesting facts concerning the delegates from the State Medical Society.

Dr. Edwin S. Hamilton of Kankakee was elected to his second five year term as Resident Trustee of the A. M. A. and Dr. J. J. Moore of Chicago was returned as Treasurer of the A. M. A.

Dr. Bernard Klein of Joliet, Dr. Fred H. Muller of Chicago, Dr. Everett Coleman of Canton, Dr. Percy Hopkins of Chicago, Dr. Charles H. Phifer of Chicago were active on various Reference committees. Dr. H. Kenneth Scatliff acted as one of the clerks for the elections held at the 102nd Annual Meeting. Dr. Harlan English of Danville, presented several resolutions developed in the House of Delegates at the May meeting of the Illinois State Medical Society.

It was brought out at this meeting, in Dr. Elmer H. Henderson's report as president of the American Educational Foundation, that Illinois led all states in the total sum contributed by its members. There had been some objection by several county societies—however when the procedure of the handling of these monies was explained, the objections were ironed out and none have refused to participate.

There were three other Illinois members seated in the House of Delegates of the A. M. A., Dr. Edward L. Compere, Chicago, for the Section on Orthopedic Surgery, Dr. M. G. Westmoreland, Chicago, for the Section on Pathology and Physiology and Dr. W. L. Crawford of Rockford for the Section on Pediatrics.

Other members from Illinois were honored: Dr. Percy E. Hopkins was chosen as President-Elect of the Conference of Presidents, and other State Society officers.

Mrs. Esther A. Fraser finished her second year as Secretary-Treasurer of the national group "Medical Society Executives." Again our own Mrs. Frances Zimmer served as group secretary of the State Association Executives.

All in all, more than 560 Illinois physicians were registered at the A. M. A. New York Meeting.

The first meeting of the Council following the annual meeting was held on June 21, 1953 at the Hotel Sherman.

This was the reorganization meeting for the coming year.

It was felt that the Council of the Illinois State Medical Society, along with the various committees had worked so harmoniously and accomplished so much, that with few exceptions and some additions, there should be little change.

Two changes were made in the committee of Medical Service and Public Relations. Dr. Leo P. A. Sweeney the retiring president was added to that committee, along with that of Dr. E. A. Piszczek, both of Chicago.

On the I. P. A. C. Committee, Dr. Everett Coleman asked to be relieved as Chairman of the Committee. He had served for many years as Chairman and felt that some one else should be appointed in his stead. I suggested Burtis E. Montgomery of Harrisburg and Dr. Coleman readily agreed that Dr. Montgomery would do a fine job in that capacity, especially as he had been on the committee for a number of years.

As Dr. Coleman was anxious to decrease his activities further he resigned also from the Advisory Committee to the United Mine Workers. Dr. W. A. Monaghan of Taylorville succeeded him in the Chairmanship for this group.

Dr. C. H. Phifer had resigned as Chairman of the Ethical Relations Committee and in his stead, I selected Dr. Arthur C. Taylor to replace him. He agreed and we continued the committee with Dr. Taylor as chairman. Also with Dr. Charles Allison of Kankakee and Dr. V. E. Adams of Macomb. Dr. Taylor has been active in the Chicago Medical Society Ethical Relations Committee and I thought he was well acquainted with this work.

The Medical Education Committee, which has been a large group, with the Chairman, Dr. Leo P. A. Sweeney presented the problem of the osteopaths to the House of Delegates at the May meeting. This committee had served its usefulness and it was thought that it should be dissolved. Nevertheless because of the Cline resolution regarding the osteopathic situation being re-activated and a request by the A. M. A. for each state to bring in its several findings at the 1954 meeting, a small three man liaison committee was appointed to present the facts to the 1954 House of Delegates of the Illinois State Medical Society. This liaison committee was chosen to be under the Chairmanship of Dr. H. Close Hesseltine and with the addition of Dr. Leo P. A. Sweeney and Dr. Jacob E. Reisch of Springfield.

One other committee which in the past had been inactive was reorganized. That is the Committee on Industrial Health. Dr. Lloyd E. Hamlin of Chicago was asked to be chairman, with the following additional members; Dr. Richard J. Bennett, Jr., Chicago; Dr. Joseph H. Chivers, Chicago, Dr. Milton H. Kronenberg, Peoria, Dr. Carl T. Olson and Dr. Carl M. Peterson, also both of Chicago.

This committee has held several meetings and formulated numerous procedures to be followed, with a resulting activity that is beyond all expectations.

After the Council had accepted the report of the committees and its changes, the meeting proceeded with its regular meeting.

President Lewis reported on his activities, giving some of the high lights of the A. M. A. meeting in New York as he saw them.

Dr. Vaughn gave his report as President-Elect, asking for support and cooperation of the Council in the coming two years.

He suggested that members of the Chicago Branches be asked to attend the Council meetings in order to see the actions and obtain some idea of the overall workings of the Illinois State Medical Society. This suggestion was enlarged upon by the Council to include members, especially officers of the various county societies throughout the state.

The dates for the future Council meetings were given at this time, with the proviso that changes could be made at the discretion of the Council Chairman.

Mr. John Neal reported for the Medical Service and Public Relations Committee. He reported on several items, the most important being the Coroner's bill, which has been put over to the next session and about all we can say is that so far it has been an educational project. The bill is in the legislature and has been through several readings and we can only hope we have made some progress.

Dr. George A. Hellmuth reported on the activities of the Postgraduate Committee.

Several Councilors reported on their various district activities.

Dr. Sweeney, as chairman of the Committee on Gamma Globulin, reported on the means of obtaining information for the distribution and use of gamma globulin for poliomyelitis prophylaxis.

Dr. Hedge reported on the meetings of the Inter-professional Council and their activities. He also stated that the dues of \$100.00 owed by the State Society were due and a motion to pay them was passed by the Council.

The meetings of the Council for August, 1953 was held on the 16th in Chicago, at the Hotel Sherman. A full Council was present.

Dr. Willis I. Lewis made his presidential report, bringing out several interesting facts as to the new administration in Washington. He also suggested that the Council allow the expenses of the Duquoin Fair exhibit be defrayed. The Council approved \$300.00 for the event as some 270,000 people attended this Fair.

Dr. Arkell M. Vaughn gave his president-elect report,

stating he attended the meeting of the Museum of Science and Industry, at which time Dr. Earl Blair was honored by the Freedom Organization for his work in the field of Civil Defense.

Dr. Harold Camp made his report as Secretary, stating that the Placement Service in the office, had aided 22 rural communities to find physicians since the 1952 report. This making a total of 100 so far.

The Council went into executive session to hear the report of the Ethical Relations Committee.

The Committee on Medical Service and Public Relations made a report on several items, one especially in regard to having the Councilors of the various Societies at the Postgraduate Meeting and any other meetings of the various county societies—present to the members of the Illinois State Medical Society—the many activities of the state society and re-emphasized the bringing of several members from over the state to the council meetings, so as to introduce them into the activities of the Illinois State Medical Society. A number of Councilors discussed and approved this action.

The Postgraduate Committee's report was complete with full information regarding budget, meetings and ideas as to the coming year. Discussions were entered into by several councilors—the feeling being that these meetings were on the whole, worth while and that the committee should be given every opportunity to experiment on various procedures to enhance and stimulate the type as well as the character of the meetings. Thus being able to increase attendance at the meetings.

The I. P. A. C. Advisory Committee met and brought in a report. The very difficult problems confronted by this committee are well handled by the Chairman, Dr. Montgomery.

Councilor reports were received.

Dr. Louis Limarzi reported for the Scientific Service Committee, regarding the speakers' lists.

Dr. Roland Cross reported for the State Health Department.

The Springfield State Fair was reported on in length by Dr. Jacob Reisch. This was one of the best meetings as to medical activities.

Dr. Newcomb reported on the Illinois Heart Association.

Dr. Goodyear on Gamma Globulin in Decatur.

Dr. Fullerton reported on the DuQuoin Fair.

The October, 1953 meeting of the Illinois State Medical Society council was held on the 18th at the usual place. Two or three of the Councilors were out of town attending other meetings.

Dr. Lewis reported his activities through the past two months, regarding the Kentucky State Medical Society, in Louisville, Mississippi Valley Medical Society in Springfield. Also on the meeting of the Advisory Committee to the United Mine Workers. The Chairman of the committee was Dr. Monaghan of Taylorville.

On October 5th, Dr. Lewis attended the Wisconsin

State Society annual meeting in Milwaukee. The Wisconsin Society has a committee to arrange their House meetings so as not to conflict with their scientific program.

President-Elect Vaughn attended the Michigan State Medical Society annual meeting on September 2, 1953. Dr. Vaughn has been interested in the simplification of insurance forms and raised the question before the Council. He submitted a resolution regarding this subject. Several councilors discussed the resolution which was finally passed by the Council.

Dr. Camp reported on several additional rural physicians located through the Placement Service and also reported on the Illinois State Medical Society Woman's Auxiliary bulletin, printed as a complimentary service for the women by Mr. Web Johnston of the Commercial Art Press, Monmouth.

As Chairman of the Council, I attended the A. M. A. meeting for discussion of the Veterans Administration problems at the Sheraton Hotel and also the public relations meeting at the Drake. I also attended a meeting of the Committee on Diabetes, of which Dr. Robert Keeton is the Chairman.

I was also present at two or three sessions of the Krebiozen hearings, the dedication of the Chicago Tuberculosis Hospital and a meeting of the Committee on Industrial Health on September 23rd.

Dr. Robert Keeton has obtained for publication in the Journal of the Illinois State Medical Society from Drs. Henry Ricketts and Masters, a paper on the experiences of doctors in Springfield, Illinois.

Dr. Hopkins reported on the Medical Service and Public Relations activities, stating that this committee has been working with the newly formed Committee on Industrial Health.

Dr. Blair reported that the Educational Committee had a meeting the day before and much discussion was brought out regarding TV. It seems that WGN can allot us time in the afternoon at 1:30 which will reach very few people. Our wish to consider the possibility of a sponsor was raised and discussed.

The matter of the expense of mailing "Health Talk" which is in great demand, was brought up and discussed.

The Postgraduate Education Committee met on September 26th and passed a resolution which is contained in the Council Minutes of the October 18th, 1953 meeting. It favors the re-establishment and re-activation of the coordinating committee for postgraduate education in Illinois, first called together in June of 1952 and comprised of representatives of all the various agencies offering postgraduate instruction in the state.

There were several other portions of the resolution regarding postgraduate instruction in the state. The committee presented a schedule of meetings throughout the state.

The committee on I. P. A. C. held a meeting on the day before the council meeting and carried on the work of the committee as well as interviewing invited guests.

Dr. Lewis introduced Dr. Rudolph G. Novick, Medical Director of the Illinois Society for Mental Health.

This organization is a voluntary statewide agency working for the promotion and conservation of mental health; the improvement of standards for the care and treatment of the mentally ill.

Dr. Novick presented the facts and asked for the cooperation of the Illinois State Medical Society. He requested a committee of three to aid this group. The suggested three following names were presented to Dr. Novick, with Council agreement:

Dr. F. G. Norbury, Jacksonville, Chairman

Dr. Oscar Hawkinson, Oak Park

Dr. C. C. Ellis, Moline

Dr. Leo P. A. Sweeney presented the fact that the Division of Civilian Health Requirements of the U. S. P. H. S. recently announced the availability of an additional supply of G. G. for use in prophylaxis against polio in the present calendar year.

This was discussed and considered, in the face of the possibility of a vaccine being developed which would render G. G. unnecessary. There was much discussion by Dr. Leonard Schuman of the Illinois State Health Department as well as others. A resolution was finally agreed upon and presented by Dr. Harlan English.

Dr. M. M. Hoeltgen reported on the Nursing Committee.

Dr. Earl Blair presented his report on Civil Defense and costs to various localities. Costs were referred to the Finance Committee.

Dr. Louis Limarzi was appointed Chairman of the Committee on Arrangements for the May Annual Meeting.

Dr. Max Hirschfelder of Centralia was appointed to fill the vacancy caused by the death of Dr. J. J. Link. This is on the Scientific Service Committee.

Dr. Hesseltine reported on the desire of the Woman's Auxiliary to extend their meeting until Thursday noon, if conflicts do not develop and to hold no evening functions in order to cooperate with the Society.

Councilor reports followed.

Dr. Reisch on the State Fair at Springfield.

Dr. Newcomb on the meeting at Quincy.

Dr. Goodyear on Membership and Postgraduate meetings.

Dr. English on the A. M. A. meeting at the Sheraton Hotel regarding the V. A. situation.

Dr. Fullerton on Postgraduate meetings and the Du-Quoin Fair.

Dr. Hamilton reported on the number of individuals of foreign birth taking the State Boards.

On November 8, 1953 a meeting of the Scientific Work Committee was held. This committee was to formulate a program for the annual Illinois State Medical Society meeting in May; getting together the various sections, arranging time and selecting chairmen for the numerous sections.

The first action was to select an Executive Committee to supervise the entire program. This was carried out in short order and it did not take too long to make all arrangements for the annual meeting.

The December 13, 1953 Council Meeting was with one or two exceptions well attended.

President Lewis made an extensive report on his activities since the last Council meeting—he having attended the Indiana State Medical Society annual meeting, October 20 through the 22nd. He also attended several postgraduate meetings, as well as presiding at the Scientific Work Committee on November 8th.

Dr. Lewis also reported on the American Nursing Association's request for action on several matters pertaining to their needs and for the assistance of the Illinois State Medical Society in having venipunctures by members of the nursing profession legalized under the statutes of this state, (when not under direct supervision of a Doctor of Medicine.) This matter was also discussed by Dr. Hamilton, Mr. John Neal and Dr. Hoeltgen, Chairman of the Nursing Committee. It is still a matter under consideration although the nurses working in institutions and under direct medical supervision should have no problem.

Dr. Camp reported that while at the A. M. A. meeting in St. Louis he learned that the Judicial Council of the A. M. A. would hear the appeal filed by the Springfield Clinic in the near future.

The Judicial Council did hear the Springfield Clinic. The members of the Clinic, as well as councilor of the district, the President of the County Society with the Chairman of the Ethical Committee, Chairman of the Council and the Secretary of the Illinois State Medical Society appeared before the A. M. A. Judicial Council. The final outcome has not been heard to date.

Dr. Otto L. Bettag as Director of the Department of Public Welfare, asked for a list of physicians whom the Society would recommend to be appointed to the Advisory Board for Services to Crippled Children. This list was on approval of the Council, forwarded to Dr. Bettag.

A Liaison Committee on Education was appointed by the Chairman to act on the request of the Cline committee for the various states, to review the thought on the osteopathic situation and report the results coming from the House of Delegates of the Illinois State Medical Society. This committee was headed by Dr. Hesseltine, Dr. Reisch and Dr. Sweeney comprised the other members.

Dr. Percy Hopkins reported for the Committee on Medical Service and Public Relations. The committee met with Dr. Carl Peterson of the A. M. A. Industrial Health, who represented the Illinois State Medical Society on Industrial Health; the Chairman of the Committee, Dr. Hamlin being unable to attend.

The Illinois State Medical Society Committee on Industrial Health has been very active since its reorganization early this year and has with the combined efforts of the A. M. A. committee compiled a brochure which was submitted to all members of the Medical Service and Public Relations Committee for review and consideration as to publication. This matter was then to be referred back to the Committee for suggestions as to distribution, after revision and printing.

A letter was read by Mr. John Neal addressed to Dr. Hopkins asking that his resignation (Mr. Neal's)

be accepted as he wished to be relieved of the legislative and related work. The Council asked that the Committee on Medical Service and Public Relations find and recommend a successor to Mr. Neal and then bring the matter to the Council for consideration.

The Chairman of the Educational Committee made a report on several matters pertaining to Health Education throughout the state.

The Scientific Service Committee Chairman reported on the speakers' list, which is in process of correction.

Dr. Roland R. Cross, Director of the Department of Public Health and Dr. Leonard Schuman were heard in Executive Session.

The report on the Ninth District was given by Dr. Montgomery in conjunction with his report on the I. P. A. C. Advisory Committee.

The Postgraduate Committee reported on the various postgraduate meetings and some of the ideas that Dr. Hellmuth has regarding them.

Dr. M. M. Hoeltgen reported for his Nursing Committee, touching on the problem of venipuncture with various ramifications which might result from legalization of same. Also reported that nursing enrollment was down 10 per cent in Illinois schools of nursing. Various plans were suggested to help out the nursing shortage.

The Finance Committee has approval to pay \$200.00 dues in the Illinois Chamber of Commerce.

That the \$10.00 dues for the Illinois Civic Exchange be allowed.

Dr. Goodyear introduced Dr. C. Elliott Bell, who discussed insurance problems in the health field.

Other Councilors reported on the Postgraduate meetings in their districts and other matters pertaining to their districts.

Dr. Reisch introduced Dr. DeHollander, Secretary of the Sangamon County Medical Society, who requested that at the I. P. A. C. meetings, various members be brought in to attend the meetings and see how the I. P. A. C. functions, in order that they may return home with a story of the deliberations and an insight into the problems faced by the profession.

Dr. Lundholm reported that the local Auxiliary to the Winnebago County Society had raised \$14,000.00 by sponsoring a concert for the nurse recruitment fund.

The time and dates for the meetings of the House of Delegates presented a problem to avoid conflict with the scientific sessions as planned for the 1954 meeting.

This year we suggest:

First Meeting Tuesday, May 18, 9:00 a. m.

Second Meeting Thursday, May 20, 3:00 p. m.

Third Meeting Friday, May 21, 8:30 a. m.

Following the Council meeting of December, it was felt that a general Council meeting need not be arranged for January—instead a meeting of the Executive Committee might well be called for late in January. This was so arranged.

The Executive Committee was first approved by the

Council on January 7, 1940 at the request of the then President, James H. Hutton. The functions as proposed at that time were:

1. To receive reports and review them before the Council meetings.
2. Present same in condensed form to the Council at its next meeting.
3. To give opinions on matters needing immediate attention provided they do not necessitate the expenditure of funds.

Thus the Executive Committee met on January 23, 1954 with a full attendance.

After short reports from the Society officers, Dr. Camp reviewed a number of previous Executive meetings, relating to the exact status of the Executive Committee.

As stated above the committee should condense, in so far as is practical, the matter of reports, new business and anything that might need to be discussed, so as to facilitate the next meeting of the Council.

Also a committee on Policy was to be created. This to be composed of the President, Chairman of the Council, Secretary and Chairman of the Finance Committee.

The Policy committee to consider the functions of the various committees and the reporting of their findings to the Council.

Dr. Camp completed his report by relating a number of matters which we will now report on.

A report from the Medical Service and Public Relations Committee was made by the Chairman, he relating the meetings concerning the resignation of Mr. Neal and the attempts to find a successor to this position.

Dr. Hesseltine reported on the progress of his committee, regarding the position of the Osteopathic affairs. Also that his committee is to compose and send out a letter to all Medical Societies as well as branch societies, asking the opinion of each society, as to the questionnaire included with the letter of explanation. This to be completed so that the report may be made to the House of Delegates at the annual meeting in May.

Dr. M. M. Hoeltgen reported on the activities of the Nursing Committee.

Dr. Hellmuth reported on the coming Post graduate meetings and outlined a plan to make a survey of the state societies to determine the needs and thoughts of the various locations throughout the State—asking for permission to use some of the Post graduate funds for this purpose. This permission was granted provided he remains within the limits of his budget.

Dr. English was requested to attend as the Illinois State Medical Society delegate to the A. M. A. meeting on Rural Health. This was the 9th annual conference, and it was held at Dallas, Texas. If Dr. English could not attend he was requested to send a suitable substitute.

Sunday, March 21st the A. M. A. held its regional conference on A. M. A. policy regarding veterans with non-service connected disability. This was held in In-

dianapolis. It was thought that several should go from the Illinois State Medical Society.

A presidents' and secretaries' conference was planned with Dr. M. M. Hoeltgen presiding, and all county presidents and secretaries invited. This was held in Springfield early in April. This meeting took the place of the Presidents' and Secretaries' conference usually held at the time of the annual meeting. The thought was that this meeting will induce many more down state presidents and secretaries to attend than when the meeting is usually held with the annual meeting.

The question of funds for printing the Number Two Volume of the Illinois State Medical Society History was raised and reports were presented. This matter was deferred to a later date.

The cost of printing the Industrial Health Brochure when revised and ready for same was discussed. This was referred to Mr. Web Johnston who gave a very fair cost price.

The Interprofessional Council was reported on as a very active group, with the election of officers in that council later in the year.

The Medical Education Fund Committee meeting was well attended with good progress being made for the subsidization of Medical Education by the various states, as well as industry. Illinois has taken the lead in this project, being the first to suggest the sending of twenty dollars, which is added to the state dues.

From what had accumulated prior to Saturday, March 13th and after attending the Saturday P. M. meetings of the Coroner's Committee, the I. P. A. C., and evening the Executive Committee meeting, it was evident that our Council meeting on Sunday would have considerable material to go over and discuss.

The Sunday, March 14th Council meeting was well attended with only one or two councilors absent. Also many guests were on hand.

Dr. Lewis' report was given at length as he had attended many meetings of importance and interest.

Dr. Vaughn reported on his activities since the last Council meeting.

In the absence of Dr. Scatliff, Dr. Camp reported on the Woman's Auxiliary request for \$600.00 to help complete arrangements for their activities during the annual meeting. This was granted by the Council.

Dr. Hopkins reported for the Medical Service and Public Relations Committee.

Reporting on the several meetings of the committee to consider candidates for Mr. Neal's position as legislative representative. At this time only a report of progress could be made.

At this time Dr. Hopkins asked for and received a wholehearted response for a resolution, endorsing the candidacy of Dr. Edwin S. Hamilton for the office of President-Elect of the A. M. A.

Guests were introduced in keeping with the policy

of the Council to invite various members, officers of county societies to meet with the Council and see first hand the amount of work handled at each meeting.

Dr. Montgomery reported on the work of the I. P. A. C. since the last Council meeting, having attended many of these meetings. I wish to commend the work of the entire committee, which regardless of the necessity of the committee, seems at times to be an endless chore.

The Committee on Industrial Health has been more or less inactive. This last year by adding a new Chairman, Dr. Lloyd Hamlin and several additional members to the committee, we have through the offices of the A. M. A. and Carl Peterson been able to stimulate and develop a report from Illinois.

This is a pilot study and much of the work throughout the state has been done by Mrs. Grigsby. Mrs. Grigsby has gone about the state interviewing both labor, management and the medical personnel interested in this field of activity. With this report which will be published we will have a working manual to help with increasing the knowledge of the entire field. The Council feels that this is a step forward to increase and improve relations under the Workman's Compensation Act. That additional copies of the brochure be made available to other interested organizations and individuals for a nominal fee upon a written request to the Illinois State Medical Society.

That the Committee on Industrial Health be authorized and directed by the Illinois State Medical Society to investigate and report to the State Society and its appropriate components any questionable or unethical acts or misconduct by a member of the Medical Society in connection with the Workmen's Compensation Act.

That the Committee on Industrial Health be directed by the Illinois State Medical Society to study and prepare specific recommendations for changes in the present Acts to improve standards of Medical Care and Administration; and said recommendation to be submitted to the Illinois State Medical Society for implementation prior to the 1955 session of the Illinois State Legislature.

Dr. Hutton reported for the History Committee. The work to develop the second volume of the History of Medicine in Illinois could be done in two ways—(1) to hire a writer and have the material prepared. (2) distribute the work among the physicians of Illinois and ask that they contribute their time and knowledge to the various phases of this work. Much of the material is now available and through the activities of Dr. D. J. Davis is nearly ready.

It was suggested that a letter be sent out to the county societies and see what interest we can develop in this project.

Dr. White, a member of the Coroner's Committee reported on the activities of that Committee. He feels that Drs. Hirsch and Levinson, with the aid of Mr. Neal, have progressed to a point where just as soon as the Bar Association gives their approval, we may

présent or have ready to present, a bill to the 1955 State Legislature. The institute of Medicine of Chicago has given \$500.00 for the promotion of these principles. He also feels that the State Society may in the near future add another like sum.

Dr. E. Piszczek reported on the meetings of the Interprofessional Council, and the completion of a revision of their Constitution and By-Laws. He asked for and received the Council's approval for this revision of the Constitution and By-Laws.

Dr. Limarzi made an extensive report on the arrangements for the annual meeting. Local committees have been appointed, and the lists mailed to all members.

It was thought that the tickets should be on hand so that all members could get what tickets they might need without the confusion that occurred last year.

Dr. Hesseltine discussed the dinner arrangements for the meeting and reported on the speaker.

Dr. Hoeltgen reported on the nursing situation as well as the Secretaries' Conference which is to be held in Springfield so as to place it within easy reach of the entire group of secretaries.

Dr. Hellmuth reported on the postgraduate committee, giving a report of progress.

Dr. Cross reported on the work of the State Health Department, stressing hospital construction as being one of the major activities of the Department. The Federal, State and local communities have given a combined total of approximately \$62,000,000.00. With these funds 46 projects have been undertaken.

Dr. Cross also reported on the law enacted in 1953 requiring the licensing of practically all hospitals in Illinois by the Department of Public Health. Also the licensing of all trailer coach parks.

Dr. Cross also reported on the pollution of the waters of the Kaskaskia River. Due to the lack of rain, wastes emptied into the stream from a plant near Tuscola, have resulted in chemical concentration in the water which appear to be toxic to fish and animal life.

The report of the Tuberculosis Control Committee was made to the Chairman, Dr. George Turner. Dr. Turner suggested that the medical profession should make every effort to have their own members X-rayed at least annually. The committee also is to arrange to have a mobile X-ray unit at the annual meeting to find out if the physicians are interested.

I brought out the fact that a letter was received from the Champaign County Medical Society relative to the appointment of lay members on society committees—specifically in this case, the appointment of an attorney to the Grievance Committee of that county society. This problem was discussed by several council members, resulting in a motion, i. e., That we notify the County Society that while the county unit is autonomous, it does have a definite responsibility to the profession as a whole, and should use extreme caution and discretion in the appointment of lay members on society committees. This was approved by the Council.

The Educational Committee was reported on by Dr.

Blair — copy having been sent in advance to the members of the Council.

This included a request for additional help in the Wabash Avenue office—another stenographer and a new folding machine.

Several councilors reported on their councilor districts, both as to local meetings and other pertinent matters.

Dr. Hamilton discussed the TV activities of the Illinois State Medical Society. He feels that the new educational television station which has already obtained somewhere in the nature of \$800,000, needing \$1,100,000 to put on a station for educational purposes, that it might be well for the Illinois State Medical Society to consider the donation of \$1,000.00 to this fund so as to obtain a hook-up with this station for educational purposes.

His suggestion was that the Executive Committee be empowered to investigate the situation and the advisability of making a donation. This may then be taken up with the Finance Committee and make such a recommendation to the Council.

Dr. J. H. Chivers reported on his trip to Louisville as a delegate from the Illinois State Medical Society to the A. M. A. Council on Industrial Health. He made a very comprehensive report on the meeting there which will be published in full.

The meeting adjourned after a very interesting and complete study of the problems set before the Council of the Illinois State Medical Society.

I want to express my appreciation of the fine services I have received during my two years as Chairman of the Council from the clerical assistants in Dr. Camp's office at Monmouth. Mrs. Zimmer has served as the reporter taking minutes of the meetings of the Council and preparing the minutes sent to the members.

The other girls, Mrs. Jane Swanson, Mrs. Wanda Ross and Mrs. Mary Ward, have all been courteous and always willing to help us in every way possible. Mrs. Ross has been official reporter for the joint meetings of the Journal Committee and Editorial Board, so she too, has been seen many times during the past two years. For their fine work, I want to give my expression of gratitude at this time.

Respectfully submitted,

F. LEE STONE, M. D.,

*Chairman of The Council.*

## REPORTS OF COUNCILORS

### FIRST DISTRICT

#### J. S. LUNDHOLM, ROCKFORD

During the past fiscal year it has been my pleasure to visit the County Medical Societies in the First District, and my privilege to present a number of memberships in the Fifty Year Club. A successful Postgraduate Meeting was held in Rockford on March tenth, and although attendance was below anticipation, the meeting was excellent. Another Postgraduate Meeting scheduled for March thirtieth in Sycamore by DeKalb County had to be canceled at the last moment because of inclement weather and hazardous driving conditions.

A rousing good Postgraduate Meeting was held in Waukegan on April twenty-first, Lake County being host.

In September 1953 Stephenson County organized an Auxiliary, and the question of organizing an Auxiliary is now about to be considered by Lake County. In October 1953 the Auxiliary to the Winnebago County Medical Society sponsored a concert in the interest of raising funds for a "Perpetual Student Nurse's Fund", designed to provide financial aid to girls desirous of entering nurse's training. The concert was a huge success and the Auxiliary netted approximately fourteen thousand dollars.

Two blood banks established in the First District continue to flourish, one in Lake County and one in Winnebago County. It is to be hoped that in the very near future all of our counties in Illinois as well as in all other states will be served by blood banks managed through their County Medical Societies, and an exchange system developed to enable blood bank members to obtain blood when the necessity arises, regardless of where they are in this country.

Respectfully submitted,  
J. S. LUNDHOLM, M. D.,  
*Councilor, First District.*

THE SECRETARY: I am sorry to report that J. S. Lundholm suffered from some type of injury which has resulted in a very severe strain and he is now in the hospital. The Council has sent a letter of sympathy to him and best wishes for recovery.

**SECOND DISTRICT**  
**JOSEPH T. O'NEILL, OTTAWA**

Your Councilor has had a very interesting and active year. The eight county medical societies comprising the Second Councilor District (Bureau, LaSalle, Lee, Livingston, Marshall, Putnam, Whiteside and Woodford) will have been visited by the time this report appears. He has been received cordially and happily reports that all is harmony with the societies, individually and collectively. Individual or combined scientific meetings have been held with fine, constructive programs.

Special dedication exercises were held May 28, for the modern new addition to St. James Hospital, in Pontiac, which is located in Livingston County. Expansion plans are also under way at the Sterling Community Hospital in Whiteside County.

During the year six memberships in the Fifty Year Club were awarded in the Second District. The members who gave so much to their profession were: Dr. George F. Blough, of Odell; Dr. Otto Balensiefer, of Peru; Dr. John D. Scouller, of Pontiac; Dr. Ernest D. Seymour, of Streator; Dr. Mathias H. Sawyer, and Dr. W. P. Fread, of Ottawa; and Dr. Snavelly, of Sterling. The presentation of these memberships and their accompanying insignia has been a real privilege. It is very inspiring to see these deserving members of our profession receiving recognition for their long and faithful service not only to their medical society, but their community.

The selection of Dr. George Dicus, Streator, a member of the LaSalle County Medical Society, as Outstanding General Practitioner of the Illinois State Medical Society was a rare honor in the Second District. His own medical society marked the event at its meeting April 8. Nothing further can be added to his eulogy.

During the year one postgraduate conference was held in the district. This occurred in Sterling, in October. It was very well attended and the program, panel discussion, was particularly well received.

Your Councilor should like to call the attention of the House of Delegates to the fact that the small schools of nursing are apparently slowly, but surely, being squeezed out of the medical picture. In the large and very populous Second District, serving approximately 200,000 persons, only one hospital still maintains a nursing school. Current factors, however, indicate that this particular hospital is imminently near, if not in actual danger, of having to close its school of nursing.

Why? The hospital is willing to maintain its school of nursing; its economic attraction is satisfactory and sound. But the stringent regulations and particular philosophy of the new concept of nurses' training set up by the accrediting boards appear to be the restraint. Thus two obstacles occur. Not only is the recruitment of young women to the nursing profession to serve their community impeded, but the employment of suitable personnel from outside the community—namely the graduates of the larger schools of nursing, is blocked. In addition, the lack of extensive cultural facilities ordinarily found in a small community looms high as an obstacle to those who might be drawn from a metropolitan area.

It is the opinion of your Councilor that too many small schools of nursing have been closed in Illinois. Surely there is some place left for the small school in the rapidly advancing progress of medicine and its allied art, nursing. Has not the small school throughout the years done valiant work to educate and keep in its community its own graduates? Is it not true that the small school of nursing has made valuable contributions to medicine and to the care of the sick? These graduates should not be forgotten, nor should those who would follow in their footsteps.

*Your Councilor thinks we must pause and consider. It may be later than we think.* Once the small school of nursing with its potential contribution is gone, the problem to reactivate will be difficult.

Your Councilor wishes to express his appreciation to the county medical societies comprising the Second Councilor District. Their cooperation lightened what could have been an arduous task. To the House of Delegates, your Councilor wishes to say "thank you" for your confidence.

Respectfully submitted,  
JOSEPH T. O'NEILL, M. D.,  
*Councilor, Second District.*

### THIRD DISTRICT

**F. LEE STONE, GEORGE A. HELLMUTH, R. C. OLDFIELD,  
JOHN LESTER REICHERT, E. A. PISZCZEK,  
H. CLOSE HESSELTINE, CHICAGO**

The Chicago Medical Society continues to develop new activities and to strengthen programs initiated in former years.

The Central Society, the fifteen Branch Societies and twenty affiliated Specialty Groups have brought the best in medical science and progress to the physicians of Cook County.

### DOCTORS' EMERGENCY SERVICE

The Doctors' Emergency Service in 1953 took care of 2,182 emergency calls. A recent survey of cases that had been taken care of by the Doctors' Emergency Service showed that all seemed very happy with the service rendered. The participating physicians on this panel are doing a wonderful job not only in saving lives but in the promotion of good first line public relations with the public.

### GRIEVANCE COMMITTEE

The Grievance Committee of the Chicago Medical Society handled 196 complaints in the past year. About 18 doctors were called in and 21 complaints were settled satisfactorily. A few cases required additional investigation. Most of the complaints are due to misunderstanding and were settled without the necessity of calling in the doctor and complainant. In some cases the Committee recommended an adjustment in fees and a friendly settlement was reached. Three doctors were referred to the Committee to Investigate and Consider Informal Charges of Unethical Conduct. A very small proportion of the number of complaints received represents justifiable grievances against physicians.

### EMERGENCY MEDICAL SERVICE

There has been no definitive administrative activity in the Chicago area to implement the statewide plans for the utilization of first aid stations and improvised hospitals during the past year as outlined in the report of the Committee on Military Affairs and Emergency Medical Service in the report of the committee to the House of Delegates at the annual meeting of the Illinois State Medical Society in 1953. Attention is directed to the report of that committee as it appears in the 1953 handbook to the House of Delegates. The lack of activity of the Health and Welfare Division of the Chicago Civil Defense Corps reflects badly upon the down-state communities involved in this plan in that no down-state community to date has acquired any first aid station or improvised hospital equipment on a community basis.

The Committee on Emergency Medical Service is in the process of making an overall study of the health services needs for the Cook County area. The advent of the hydrogen bomb has necessarily enlarged the scope of calculations in this study. This committee is consulting with representatives of the allied health professions including the medical components of the armed forces. The development of any civil defense facility

seems to be in proportion to the degree of active endorsement and continued support given to the program by local government administrations involved.

### COMMITTEE TO INVESTIGATE AND CONSIDER INFORMAL CHARGES OF UNETHICAL CONDUCT

The committee has been very active throughout the year considering all cases which have come up before it and referring considerable work to the Ethical Relations Committee.

During the year 10 cases were called in before the committee, but in only three of these cases was it recommended to the Council that charges of unethical conduct be preferred.

### ETHICAL RELATIONS COMMITTEE

The Ethical Relations Committee has been active and has met problems as they were presented.

### MEDICAL SERVICE

As usual the Medical Service Committee is available at all times to handle any problems which might fall within its jurisdiction.

### CLINICAL CONFERENCE COMMITTEE

The Annual Clinical Conference of Chicago Medical Society was initiated in 1944. It was designed to prepare an annual program for the physicians of the Chicago area and environs. The Conference has been arranged yearly extending over a period of four days. Most of the program has consisted of thirty minute lectures but television and demonstrations have also been utilized. For a time emphasis was placed on television but due to certain limitations the program was changed slightly to utilize demonstrations for a few hours each day simultaneously with the regular program. The demonstrations were designed for a small audience but an attempt has been made to show particularly how certain therapeutic measures are carried out.

In 1954, Smith, Kline and French who have sponsored our television programs adopted the use of a five foot screen. Utilizing only one screen it was possible to show operations and clinical demonstrations to the entire audience. Demonstrations were carried out for a few hours each day to allow some choice of program for the audience.

There has been a gradual increase in interest throughout the years. The total attendance for the first year was 2,151 and 5,263 for the past year. The lectures have been accumulated and assembled in a small volume which can be purchased from the Chicago Medical Society each year.

### PRESS RELATIONS

The Committee is active and is frequently consulted to act regarding censorship in connection with proposed articles or appearances on radio and television and it has also cooperated in providing several press releases.

### TUBERCULOSIS CONTROL COMMITTEE

The Tuberculosis Control Committee, Chicago Medical Society, has held monthly meetings preceding the council meetings of the Society.

Many interesting developments are slowly coming to fulfillment after having had the Medical Society's recommendation for a good many years. This is the ninth

year that the Chicago Medical Society Tuberculosis Control Committee has been active and some of the recommendations made in the first year are now slowly reaching fulfillment.

The following outstanding achievements took place during the past year:

1. Dr. J. J. Moore, Treasurer of the American Medical Association, was appointed as the Board of Health representative on the Municipal Tuberculosis Sanitarium staff. Dr. Moore is also one of five members of the Chicago Board of Health.

2. The Municipal Contagious Disease Hospital has been enlarged to accommodate 100 children at this time and it is expected that this capacity may in time be doubled. All of the children from the Municipal Tuberculosis Sanitarium were transferred to the facilities of the Municipal Contagious Disease Hospital, thus enlarging the facilities at Municipal Tuberculosis Sanitarium for adult care.

3. The legislature of the State of Illinois increased the peg levy of the Municipal Tuberculosis Sanitarium to 5½ million dollars a year.

4. Enlargement of facilities at North Riverside Branch of the Municipal Tuberculosis Sanitarium. An additional 75 beds were made available by rehabilitating the North Riverside Branch at 22nd Street and Harlem Avenue.

5. The State Health Department subsidiary appropriation of 5 million dollars for the biennium remains the same but the subsidiary for counties needing care has been increased from \$3 to \$4 per patient per day.

6. The Chicago State Tuberculosis Sanitarium was opened in the late fall of 1953 and at the present time has increased its facilities to accommodate approximately 120 patients.

7. The Illinois legislature passed the law increasing the membership of the Suburban Cook County Tuberculosis Sanitarium District Board of Directors from three to five members.

8. The facilities for the care of Suburban Cook County tuberculosis patients are being built at the 40-acre site at 55th Street and County Line Road, Hinsdale, and the opening of these facilities is scheduled for October 1, 1954. Facilities will accommodate 174 patients. The cost of this institution is about 3½ million.

9. The Tuberculosis Control Committee recommended to the City of Chicago that all of the inmates of the Bridewell (House of Correction) be screened by admission X-rays. This program was placed in operation in April, 1954.

10. The Tuberculosis Control Committee has recommended to the Cook County Board of Commissioners that all of the inmates of the Cook County Jail be screened with an X-ray for tuberculosis on admission and on discharge. Although this recommendation was made in early November, progress in this regard has been very slow. It is hoped that this program may be placed in operation some time this summer.

11. The Tuberculosis Control Committee had recommended to the Illinois legislature the passage of a public

protection law giving health officials the power to hospitalize open cases of tuberculosis when necessary. Although the law was passed by the legislature, it was vetoed by Governor Stratton on the basis that it was unconstitutional in some of its provisions.

12. The committee had recommended extension of hospital admission X-rays and it is gratifying to note that more and more hospitals are doing admission X-rays. Approximately one-fourth of all hospitals at the present time are screening all admissions for tuberculosis.

13. A sub-committee of the Tuberculosis Control Committee has been studying the problem of making every doctor's office a tuberculosis detection center. The committee has had several meetings with leading medical-tuberculosis authorities and it is hoped that a progressive educational program among physicians at the local hospital level will be inaugurated in the fall of 1954.

14. Out-patient therapy prior to admission and following sanitarium care has been greatly accentuated by the Municipal Tuberculosis Sanitarium. Two-thirds of the problem of tuberculosis at the present time is the male population and the year 1954 found the tuberculosis agencies with no female waiting list.

15. The Tuberculosis Control Committee has noted the decrease of patients in the lower age group and the increase of patients in the upper age group and feels that extensive efforts should be made through communities, industries, churches, and schools to educate people to have a yearly chest X-ray so as to detect tuberculosis as early as possible. At present, more than 50 per cent of the cases found on the original report are already in the far advanced stage. It is hoped that by a campaign of having everybody X-rayed yearly that tuberculosis may be found in the minimal stage more often and less patients need be hospitalized, and the length of stay and complete return to normalcy is greater in this stage. The committee has several times considered making it mandatory for all adults over 15 to have a yearly chest X-ray.

## CHILD HEALTH

The Child Health Committee has been enlarged and the scope of its work has broadened in the past year. Its main concern, however, continues to be the Chicago School Health Program.

The budget of the Bureau of Health Services of the Chicago Public Schools was substantially increased at the beginning of the year, permitting an increase in personnel and in the activities of the Bureau. The hearing and vision screening program has now reached practically all of the children in the public schools. The addition of seven more teacher nurses and another supervisor has almost doubled the number of school health councils. A member of the Chicago Medical Society plays a prominent role in each of their councils in solving the health problems of each school involved.

The outstanding development in the program has been the appointment of Marie A. Hinrichs, M. D., as Di-

rector of the Bureau. Dr. Hinrichs is the Editor-in-Chief of the Journal of School Health and a recognized national authority in her field. She comes to us from the University of Illinois where she has been Associate Professor of Health Education. She will shortly transfer her membership from the Champaign County Medical Society to the Chicago Medical Society. Dr. Hinrichs has already stressed the fact that the active support of all physicians is essential to the continued growth of the program.

#### GAMMA GLOBULIN COMMITTEE OF CHICAGO

In June of 1953 the Chicago Medical Society appointed Eugene T. McEnery and John Lester Reichert to act as an Advisory Committee to the Chicago Board of Health in implementing the directives of the Illinois State Department of Health for the allocation of gamma globulin in poliomyelitis contacts in Chicago. No serious problems of distribution developed during the epidemic.

Since the epidemic of 1953 demonstrated that gamma globulin is of no value in the prevention of poliomyelitis in family contacts, and of questionable value in group exposures, the procedure as set up by the Illinois State Department of Health will be different this year.

The Chicago Medical Society will again advise with the Chicago Health Department in carrying out these procedures.

#### COMMITTEE ON HEALTH AND ACCIDENT INSURANCE

The Chicago Medical Society at its June, 1953, council meeting passed a motion to accept a Health and Accident Group Insurance master policy for true group insurance for the members of the Chicago Medical Society. This policy was selected from a number of plans submitted to the Committee on Health and Accident Insurance. At the same meeting the council chose C. O. Finley and Company to serve as the enrolling agency and the Lumberman's Mutual Casualty Insurance Company of Chicago was selected as the carrier. In the autumn of 1953, the broker began the enrollment of the eligible members of the Chicago Medical Society and by January, 1954, over 50 per cent of the eligible members of the Chicago Medical Society were enrolled. This successful enrollment made it a true group plan. The eligibility for enrollment extends the age to 70 years. In special instances it might be necessary to give them type B or C contract if there seemed special risk, but at the regular premiums for these plans. There was the option of post-dating the effective date of insurance.

Some of the points of this Health and Accident insurance include an eight day waiting period for illness unless hospitalized, five year sickness benefits and a lifetime clause for accident, and a clause for partial disability after the complete disability. There is no prorating of benefits regardless of the amount of other health and accident insurance.

As the new members come into the society they will have an opportunity for 6 months to enroll and these enrollees may elect a post-dated time for effective in-

surance up to 12 months. The council appointed a special committee to assist and observe the enrollment of the members (for the protection of the members), and to serve as a committee to which problems or complaints of its members on Health and Accident insurance could be referred, and to serve the individuals in instances of disputed claims.

#### ILLINOIS MEDICAL SERVICE (BLUE SHIELD) BLUE CROSS

During the past year continued progress has been made by the two non-profit prepayment plans with headquarters in Chicago, namely Blue Cross Plan for Hospital Care and the Blue Shield Plan of Illinois Medical Service.

The Blue Cross Plan for Hospital Care with headquarters in Chicago paid hospitals \$33,845,259 in 1953 and closed the year with a membership of 2,052,969. This plan now serves residents of 93 counties in Illinois.

During the year 308,852 members received hospital benefits. Reserves at the close of the year were \$4,705,000. The operating expense was 8.19% which is the lowest in the history of the Plan.

The Blue Shield Plan of Illinois Medical Service is now operating in 97 counties and at the end of 1953 had a membership of 930,014. This means an increase of 139,528 members during the past year. 115,679 cases were paid a total of \$6,202,968. Reserves total \$4,391,767 indicating an eminently sound financial condition. Since its inception the dues paid by Blue Shield members have remained the same in spite of an appreciable increase in benefits paid.

Effective about July 1, 1954 a revised certificate will be issued with increased benefits but without any increase in the membership dues. Consideration is being given to the offering of other certificates carrying a higher schedule of payments for groups which might desire such increased coverage.

#### POSTGRADUATE COURSES

Two postgraduate courses sponsored by the Chicago Medical Society were held during the weeks of November 9 to 13 and November 16 to 20, 1953 at the Sheraton Hotel. The first course given was "Hematology and Cardiology" and the second course was "Obstetrics and Gynecology."

Since their inception in 1947 the postgraduate courses have been an outstanding success. The 1953 courses attracted a record number of physicians from all parts of the United States and Canada. The courses are open to physicians in good standing in their county and provincial medical societies.

The abstracts of all papers in book form given to those attending have proved to be very helpful and so much in demand that similar books will be distributed to those registering for the 1954 courses.

In the fall of 1954 a course in Basic Principles and Recent Developments in Internal Medicine will be given during the week of November 8 to 12 and a course in Basic Principles and Recent Developments in General Surgery will be given the week of November 15 to 19 at the Sheraton Hotel. It is hoped that a large number

of physicians from Cook County and the rest of the State will avail themselves of the opportunity to attend the 1954 postgraduate courses.

#### PUBLIC RELATIONS

The members of the Public Relations Committee of this District are:

Charles W. Bibb, M. D.; R. H. Hayes, M. D.; C. M. Epstein, M. D.; A. J. Linowiecki, M. D.; F. H. Muller, M. D.; K. L. Vehe, M. D.; and H. K. Scatliff, M. D., Chairman.

The Committee has had regular meetings concerning itself with matters called to its attention by the public welfare organizations, civic organizations, hospitals and individuals.

A) They have dealt with overcrowding of our hospital clinics due to inability of a certain strata of society to secure private medical care within their means.

B) They have discussed the growing tendency of a small segment of the profession to display advertising signs rather than restrained signs of identification only. This tendency has resulted in signs of huge size, lighted signs, neon signs and those of colored lights. This, the Committee feels, is in conflict with good professional taste and conduct and we urge the profession to familiarize themselves with the Committee's recommendations on this subject as printed in the Bulletin of the Chicago Medical Society.

C) The matter of the doctor and his automobile, especially as related to parking when making a professional call, has recurred several times. It has been deemed of such importance that a special committee is now studying the subject.

The Committee had a display to illustrate its activities at the time of the Public Relations Meeting of the American Medical Association at the Drake Hotel in September, 1953, and also we are grateful to the Public Relations Department of the American Medical Association for their continued interest and help. The Committee prepared an additional exhibit on the occasion of the annual meeting of the Chicago Dental Society February 7-10, 1954. Featured in that exhibit was the pathology in which medicine and dentistry are jointly interested. Its keynote was "Medicine and Dentistry Join Hands. Their concern is the patient's general health."

The Committee has been appreciative of the help of Mr. James C. Leary, Director of the Public Relations Department of the Society and has been helpfully guided by the outline of a program entitled "The Public Relations of County Medical Societies," prepared by the Committee on Medical Service and Public Relations of the Illinois State Medical Society.

#### WOMAN'S AUXILIARY ACTIVITIES

The activities of the officers of the Woman's Auxiliary to the Chicago Medical Society for the year began with their installation on May 12, 1953.

Your president visited eight of the eleven branches during the year. She installed the officers of the Northwest and Jackson Park branches. At all eight meetings greetings from the county auxiliary were

given and the assurance of full cooperation was extended to each branch.

The first official meeting of the council came on Wednesday, May 27, 1953. The committee chairmen received approval at this time. The school of instruction which followed was arranged by the three directors. The parliamentarian, Mrs. Arthur G. Hohaupt, instructed the new officers on their respective duties.

The woman's auxiliary on the request of Dr. Eugene McEnery, Dr. Percy E. Hopkins and Mr. James Leary sent telegrams and letters to their respective senators and representatives in Springfield to oppose Senate Bill 464 (Chiropractor Bill).

The first Mental Health chairman for the county auxiliary was appointed and approved at the January, 1954, council meeting.

The history of the first 25 years of the auxiliary was published and distributed during the fiscal year.

A complete revision of the Constitution and By-Laws was started in the autumn of 1953 and is scheduled for completion by October, 1954.

The council of the auxiliary at the March meeting passed a motion to the effect that each year the President's Annual Report to the state auxiliary be placed on file for the purpose of making a composite history at times suitable to our successors. Therefore, this report will be the first in this series which is the 26th year of the existence of an active progressive united auxiliary.

During the year there was a total of eight council sessions. General meetings were held four times. The first general meeting was devoted to routine business. A special meeting was called on November 17th for a joint program on Public Relations and Nurse Recruitment. Dr. Stanley P. Reimann, noted cancer pathologist from Philadelphia, spoke on "Cancer Today" to a total audience of 400 people in the Gold Room of the Congress Hotel. Representatives from various organizations were invited guests. Representative graduate, "in training" and prospective nurses were present. The auxiliary appreciates the action of the trustees and advisors in this yearly project. Many letters were received congratulating the doctors' wives on this splendid public relations program.

The theme for the second general meeting in January, 1954, was "Know Your Community." Dr. Harold W. Miller was the guest speaker.

The Honorable Judge J. H. Braude talked on "What Is Being Done to Prevent Delinquency in Your Community" at the third general meeting on March 9, 1954. Immediately after Judge Braude's lecture the officers for 1954-55 were elected.

The fourth and last general meeting was also the annual meeting. Miss Dorothy Rafilson gave a solo, dramatic program. Immediately preceding adjournment the new officers were installed. They were as follows: President, Mrs. Eugene McEnery; President-Elect, Mrs. Leonard J. Houda; Vice President, Mrs. Charles Vil; Recording Secretary, Mrs. Gene Wong; Treasurer, Mrs. Nicholas G. Chester; Corresponding Secretary, Mrs. Rosario Drago; and Directors, Mrs.

Henry Christiansen, Mrs. Lewis Hare and Mrs. H. Close Hesseltnine.

To date—Amount donated to Benevolence—\$1,938.00.

Bulletin Subscriptions—136.

Membership—884.

Today's Health subscriptions—283.

Nurses Loans—\$800.00.

Nurses' Scholarships—\$600.00.

Known Recruits—19.

Students contacted for Nurses—60.

GRACE HESSELTINE (MRS. H. CLOSE) *President, Woman's Auxiliary to the Chicago Medical Society.*

#### VETERANS SERVICE COMMITTEE

There has been considerable controversy over free hospitalization for the veteran with a non-service connected disability. This controversy is not only local but of national interest. Regional meetings with representatives of local medical societies and officers of the American Medical Association have been held. One such meeting was recently attended by members of the Veterans Service Committee at Indianapolis, Indiana.

It is the opinion of this committee that a workable plan must be developed whereby the needy veteran will be given adequate medical attention. Future meetings are being planned in an attempt to reach a satisfactory solution to this problem.

Respectfully submitted, F. LEE STONE, M. D., R. C. OLDFIELD, M. D., JOHN LESTER REICHERT, M. D., H. CLOSE HESSELTINE, M. D., GEORGE A. HELLMUTH, M. D., E. A. PISZCZEK, M. D., *Councilors, Third District.*

#### FOURTH DISTRICT

##### CHARLES P. BLAIR, MONMOUTH

As Councilor of the Fourth District, this past year's activities have been most enjoyable. There have not been too many unpleasant occurrences in the County Societies. The cooperation from component units, both officers and members has been most cordial and has been greatly appreciated by the Councilor. Meetings of the County Societies have been held regularly, the programs have been of excellent standards, and the attendance has averaged higher than in recent previous years. Two of the ten Counties in this Fourth District have such a small number of practitioners within their boundaries that meetings are very difficult to maintain. Two of the ten societies issue a "bulletin" regularly. These publications present one or more articles on a scientific subject and items of local news. They also present pertinent information for their members concerning subjects brought to their attention by the State Society's Secretary.

This Councilor has had the honor and privilege of serving in Committee work in the following manner: As a member of the Council's Executive Committee; as a member of the Medical Advisory Committee to the Illinois Public Aid Commission; as a member of the Sub-Committee on Drugs from the Advisory Com-

mittee; as a member of the History Committee and as Chairman of the Educational Committee.

In this work your Councilor has been fortunate enough to be present at every meeting, save one, of the various committees. He has not been absent from any meetings of the Council this year.

The Fourth District has had no disciplinary problems this year and no mal-practice suits have been entered or projected against any of our members.

It might be brought to your attention also that appointments to committees for the conduct of the work of the State Society, have included members from each of our local units.

The Fourth District was host to two Postgraduate Conferences, Rock Island County Society being host to one meeting and Henry County to the second one. The Iowa-Illinois Central Medical District was also associated with the Rock Island Society as host to their conference. This was the only assembly in which such an association has been attempted and the result was a most satisfactory one for both organizations. This meeting was well attended, with a superb program and was very satisfactory in every detail. At the second conference a most illuminative address concerning the Illinois State Medical Society was delivered by our illustrious President, Dr. Lewis, and this address was broadcast over a local radio station. This broadcast provided a most remarkable effect in Public Relations for the Medical profession of that community.

A survey of the practicing physicians in the Fourth District finds that there are 564 physicians who are residing within its confines. All but 23 are members of an organization, making a total of 541 members, 96.2%. Of these physicians who are not members, most of them are men who are reported as aliens. The membership in each respective Society is as follows: Fulton, 32; Hancock, 17; Henderson, 3; Henry-Stark, 37; Knox, 53; McDonough, 27; Mercer, 7; Peoria, 215; Rock Island, 126; Schuyler, 6; and Warren, 18.

The need for additional M. D.'s in our District is not felt in any community to any appreciable degree. Deaths, removing older men who have long been a part of smaller villages, have of course presented an immediate problem. For the most part readjustment to acceptance of not too distant facilities has solved the difficulty.

A very pleasing fact is noted in the attitude of individual members, in their active participation in the civic and political affairs of their communities. This condition has been very gradual in its change from the "Ivory Tower" attitude but has been very definite and progressive in this District.

Association in this official capacity with other men of the Society has been very pleasant for the Councilor of the Fourth District. It is his sincere desire to truly express his thankfulness.

Respectfully submitted, CHARLES P. BLAIR, M. D., *Councilor, Fourth District.*

#### FIFTH DISTRICT

**JACOB E. REISCH, SPRINGFIELD**

Medical affairs and activities have continued in a progressive trend during the past year in the Fifth Councilor District. Most of the component county societies have held regular meetings and many interesting scientific programs have been presented. Despite the ever increasing number of medical meetings, attendance at meetings at the county level has been fairly well maintained and in some instances increased, due, no doubt, to the need for discussions concerning the many problems facing the medical profession today.

Several State Society functions have taken place in the Capitol City during the past year and this Councilor has served in a liaison capacity in effecting plans and arrangements for many of these. As is usual for each alternate year when the legislature is in session, considerable activity took place in Springfield concerning the various bills introduced relative to and affecting medicine. The Committee on Medical Legislation made several appearances before the legislature and I had the privilege of attending many of these hearings.

In August an improved State Society exhibit was presented at the Illinois State Fair and, this year, for the first time, kept open days and evenings for the entire ten days of the Fair. Four impressive AMA exhibits, "You and Your Medical Care," "How Disease Bacteria Are Spread," "Maternal and Child Health," and "Where Your Medical Dollar Goes," as well as four unusual medical movies. "The Story of Wendy Hill," "Your Doctor," "How To Catch A Cold," and "Losing To Win," commanded a large audience. This booth was again, for the fifth consecutive year, staffed by the Auxiliary of the Sangamon County Medical Society, who distributed many thousands of pieces of literature. Plans underway for 1954 include a double booth and improved arrangements for the exhibits.

On April 4, the State Secretaries Conference met in Springfield for an all day session and a very interesting and instructive program was presented. This marks the third time in the history of the Secretaries' Conference that it has met at a time other than the Annual Meeting.

The annual spring Postgraduate Conference on April 22 for Sangamon County and the adjacent area commanded a large attendance, unquestionably due to the inclusion of medico-economic and medico-legal discussions. Included in the program, to which dentists and attorneys were invited, were the subjects "Tax and Estate Planning for Professional Men" and "The Trial of Malpractice Cases."

During the past year meetings of the Fifth District county medical societies have been attended and various subjects concerning State Medical Society activities discussed both formally and informally. Six Fifty Year Club pins and certificates have been presented in this Councilor District.

One outstanding development has been the dedication of the new 102-bed Abraham Lincoln Memorial Hospital in Lincoln, Illinois, on April 2. Initial planning

and fund raising for this hospital instituted more than 14 years ago was halted because of the war. With the passage of the Hill-Burton Act, public-spirited citizens of this community raised the necessary funds to enable the project to become a reality.

The Fifth Councilor District, and Sangamon County in particular, will this year be honored by the election of Mrs. Ruby Kwedar, Springfield, as president of the State Auxiliary.

In addition to attending all Council meetings and several State Postgraduate Conferences, I have also served as a member of the Editorial Board of the Illinois Medical Journal and as a member of the Liaison Committee on Medical Education, Veterans Medical Affairs Committee, the Constitution and By-Laws Committee, the Voluntary Prepayment Plans for Medical and Surgical Care Committee, and the Postgraduate Educational Committee. Also, several committee meetings and sessions of the House of Delegates were attended during the AMA Annual Session in New York City.

As Councilor, I have gratefully appreciated the cordial reception at all the meetings I have attended and wish to thank the officers and members of the component societies for their courtesy and cooperation.

Respectfully submitted, JACOB E. REISCH, M. D.,  
*Councilor, Fifth District.*

#### SIXTH DISTRICT

**WARNER H. NEWCOMB, JACKSONVILLE**

The Councilor year opened in June, 1953, with a meeting at the Jacksonville Country Club, celebrating the 50th year of practice for Dr. Frank A. Norris of Jacksonville. One hundred and twenty attended the meeting from various surrounding counties. Remarks were made by Dr. Charlie Patton of Springfield.

Passavant Memorial Area Hospital, capacity 140 beds, was opened about the first part of July. This hospital was made possible through the Hill-Burton Bill.

A postgraduate conference was likewise held in Jacksonville in the month of November with a very good attendance. The program was put on by the University of Chicago. Another postgraduate conference was held at Carlinville, March 18th, this is the first postgraduate conference to be held in that city. The program was put on by the Cook County Graduate School of Medicine, it was excellent and held the attention of the audience. The evening program was held in the dining room of Blackburn College, where approximately seventy-five were present.

Adams County was visited in September, where a lively discussion was heard in reference to Television shows put on by the local County Medical Society. Madison County was visited in February, where a very interesting presentation on Public Relations, by Dr. Bell of Decatur, was well received and provoked considerable discussion.

Respectfully submitted, W. H. NEWCOMB, M. D.,  
*Councilor, Sixth District.*

**SEVENTH DISTRICT**  
**ARTHUR F. GOODYEAR, DECATUR**

In reporting on the Seventh District it is pleasant to comment that the affairs of all component Societies have been running most satisfactorily. No particular problems have arisen, and all societies are active and keenly alert to the pressing times.

Postgraduate sessions have been one of the high points in this district, major conferences being held at Taylorville on December 10, 1953, and Effingham on February 24, 1954. Both were outstanding because of attendance and interest shown. The meeting at Effingham was held in the beautiful new St. Anthony's Hospital, built since the tragic fire which took a toll of seventy-five lives in 1948. Over one hundred registered for the conference, which was given by The Stritch School of Medicine. Numerous small groups toured the Hospital during the day. The Taylorville Session, held in the Hotel Frisina, was well attended also. The panel of speakers were members of Hines Hospital Medical Staff.

One of the most pleasant duties as your Councilor is the presenting of Fifty Year pins and Certificates. This year there were four. On two occasions large community meetings were held to honor the recipients. The entire countryside turned out on July 30th, 1953, for Dr. John Shore of Sailor Springs. Dr. J. G. Lamb of Cerro Gordo was honored with a community gathering to celebrate the event. The occasion was promoted by the Lions Club of Cerro Gordo, of which Dr. Lamb is a member, in the Community High School. Dr. Harlan English represented the Illinois State Medical Society, my absence being due to conflict of programs. Certificates and Pins were also presented to Dr. DeWitt T. Brown at Bond, a County Medical Society meeting at Greenville, June 16, 1953, and to Dr. C. M. Wright at his residence at Altamont in March 16, 1954. Dr. J. R. Burnett, President of the Effingham County Society accompanied me to present Dr. Wright's award. This scores fifty per cent in Community celebrations for men completing 50 years of service, creating good public relations.

The opening of St. Anthony's Hospital at Effingham is filling a great need for a wide area. The institution is magnificent, and from the standpoint of construction is considered to be the ultimate in hospital building. This was made possible by virtue of the fact that funds were donated from all over the nation, also Hill-Burton Act funds amounting to \$4,500,000. All was invested in this institution which will undoubtedly stand as a monument for a hundred or more years.

A new hospital at Taylorville, St. Vincent's, a \$2,500,000 institution, is reaching completion. It, too, will serve another progressive and rapidly growing area.

Decatur and Macon County Hospital's approximately \$2,000,000 addition is becoming a reality. The money was made available through public spirited citizens and Hill-Burton Act funds as was St. Vincent's at Taylorville.

Macon County Medical Society keeps at its Public

Relations program. The Press Code continues to attract considerable attention, having been written up extensively in the February 6th issue of *Editor and Publisher*, a journal representing the newspaper profession. This code has been adopted by societies in many cities, and letters have poured in from all over the country and Hawaii. Interest in the success of this code was reflected in the invitation to Edward Lindsay, editor of the Decatur Herald and Review, to author an article for the Committee on Medical Economics in the Illinois Medical Journal. This comprehensive and pertinent presentation was published in the January issue under the title "Deadline Medicine."

Another project of the Public Relations Committee is a Nursing and Rest Home Survey. It will urge, following the initial inspection tour, the establishment of an annual inspection with periodic reports of improved facilities.

Public Relations throughout the district were given impetus by the Gamma Globulin programs. One was held in Decatur and Macon County in July, 1953, and in Shelby County in September. Wholehearted cooperation was given by the Medical Profession, its Woman's Auxiliary, Nurses, Nurse Aides, Red Cross, Gray Ladies and other personnel and by men and women of Service Clubs and Civic organizations. The response was an inspiring thing to observe. Support of this type in civic welfare need on the part of the profession, a willingness to share the work load, has paid tremendous and gratifying Public Relations dividends.

A Drivers' Training Program being promoted through High Schools is another facet in Public Relations. The work is being augmented with displays showing causes and results of automobile accidents. These fine exhibits are presented cooperatively by the Indiana State Police and the Bureau of Exhibits of the American Medical Association.

The Insurance Committee is engaged in organizing a large conference and meeting to be held in September. A Health Insurance Grievance Committee is being promoted in order to spread responsibility over all involved. There also is a move to create a local office cooperative plan to collect all insurance premiums. This method is patterned after a rural health plan of volunteer collection of premiums due, in order to avoid cancellations and disagreeable consequences when premiums are not paid up on presentation of claims.

Respectfully submitted, ARTHUR F. GOODYEAR,  
M. D., *Councilor, Seventh District.*

**EIGHTH DISTRICT**  
**HARLAN ENGLISH, DANVILLE**

The past year has brought no unusual problems to the forefront in the Eighth District. Each of the constituent societies in our district has conducted its affairs in an admirable fashion.

The quality of the scientific programs has been good. Every effort is being made to get a circuit rider type of postgraduate experiment in operation in our district. There are many problems attendant to this type of educational approach. The difficulty of keeping interesting

cases long enough to arrange a meeting with the traveling professor has been evident. It is hoped that the Edgar, Douglas, Lawrence, Crawford, and Richland County Societies will be served during the month of April.

The problems incident to the operation of tax supported medical care constantly plague the County and the State Medical Society membership. As a result of many years of effort on the part of local county tax-supported medical care committees, the situation appears to me to be much improved over ten years ago. Since tax-supported medical care will either be operated by political groups or medical groups, it seems to me incumbent on the members of each County Medical Society that they make the programs work within the framework of medicine.

The problems of non-citizen physicians, as well as graduates of foreign medical schools, seem to be increasing in number. There is no apparent easy solution to this problem. Some societies are using a probationary membership status to ascertain the true accomplishments of many of these graduates.

Your Councilor was requested to sit in on one Grievance Committee meeting involving physicians in two different counties.

One of the most pleasant duties of a Councilor is to present to our fifty year brother practitioners their certificates and gold awards. The manner in which communities express their gratitude for fifty years of service by a fellow practitioner is certainly eloquent evidence of what each of us owes to those who went before.

Respectfully submitted, HARLAN ENGLISH,  
M. D., *Councilor, Eighth District.*

#### **NINTH DISTRICT**

##### **BURTIS E. MONTGOMERY, HARRISBURG**

The County Societies of the Ninth District have been active with regular meetings and good attendance. No serious problems have arisen during the past year.

There have been some interesting and well attended Postgraduate meetings in the Ninth District. The idea of panel presentation and discussion seems to have been more popular than just the reading of papers. Your Councilor feels that more such meetings would be well received in the Ninth District.

There is one member eligible for 50 Year Club membership, and this presentation will be made as soon as local arrangements can be completed. This is in Edwards County.

More and more emphasis is being placed on Public Relations. Several meetings in this district have been held which were of particular interest. The Franklin County Society held a joint meeting with the Dentists and the Bar Association. Talks were made by your Councilor, a member of the Dental Profession and a member of the Bar Association. The Saline County Society has a liaison committee that works with the committee from the Bar Association in working out problems on Expert Testimony. This I think will help greatly in coordinating the relationship of the Doctor

and Lawyer, especially in the damage suits from injury not covered by the Illinois Compensation Laws.

Another problem that continually comes to our attention is the lack of standardization of Insurance Forms. The men in the Ninth District feel that a more concerted effort should be made to bring about some form of standard insurance forms.

This is election year again. It is the opinion of your Councilor that we should not relax our vigil in so far as socialization of medicine is concerned. We should as citizens, know what the men stand for that we support for our State and National offices. There are several bills in Congress which vitally affect our Profession. We should find out the attitudes of the candidates we support, on this vital legislation.

Your Councilor wishes to express his appreciation for the help and cooperation of the officers and members of the County Societies of the Ninth District. He also wishes to thank the members of the Council and the officers of the State Society for their fine cooperation and friendship.

Respectfully submitted, B. E. MONTGOMERY,  
M. D., *Councilor, Ninth District.*

#### **TENTH DISTRICT**

##### **WILLARD W. FULLERTON, SPARTA**

I am happy and proud to report that the doctors in the Tenth Councilor District are maintaining their respective individualities and are keeping up their professional decorum in spite of a devastating income tax; numerous, sundry and all sizes, shapes and designs of insurance forms; changing office girls; attending staff meetings, and trying to work in a little postgraduate work; but, otherwise they keep plugging along pretty well. I believe for the most part the integrity of the rank and file of the membership of the Tenth District is good. We have had one or two unfortunate things happen, which of course happen to doctors occasionally; but, certainly nothing to bring down condemnation on the profession as a whole. I think, for the most part, the doctors in the Tenth District do a pretty good job of keeping up with the trends of new and modern medication. I have noticed that some of the medical societies have been a little more diligent about having meetings and discussing things that are of professional interest.

There has been one women's auxiliary organized during the past year; that being in Perry County.

We have had two postgraduate conferences. One of the large type panel organization and one of the small type. The larger postgraduate conference, which was held at Cairo, in November, was a very good conference and the scientific material presented was good. The guest speakers and their friends had a very enjoyable goose hunt during their stay in Cairo. The smaller type of postgraduate conference held at DuQuoin in October was not too well attended, although the material presented was excellent.

There are of course many problems that come up: To mention—medical organization, medical economics and postgraduate work that cannot be discussed nor settled in a councilor report.

It is my opinion that the postgraduate education problem is a confusing one, and probably needs to have a new approach. Some members of the postgraduate committee have some ideas that are good but some of them may not be practical.

The question of general practitioners is an impending one; and the future of the general practitioners is one that some solution should be endeavored to be brought about in order to preserve this grand phase of medicine. It may be that the only salvation for the general practice of medicine in the future is to require all medical graduates to spend three to five years in general practice before they be allowed to take up a specialty. It certainly would make for a more rounded medically educated man, for a specialist to have served time as a general practitioner. This, of course, is a further extension of time involved in the infancy of our future specialists. I do not believe it would be time lost and I believe it would result in a better choice of a specialty; also, it would aid some of our rural communities in getting additional help.

I apologize that some of the above may not be true material for a councilor report but I think it represents some of the thinking that goes on in the Tenth District.

Respectfully submitted, WILLARD W. FULLERTON, M. D., *Councilor, Tenth District.*

#### **ELEVENTH DISTRICT**

##### **EDWIN S. HAMILTON, KANKAKEE**

Your Councilor has visited all of the component societies the past year and is happy to report they are holding regular meetings. Membership in the society is at a high point. Practically all qualified physicians are members of the society.

The Postgraduate Conference was held in Kankakee and the attendance exceeded one hundred and fifty. An excellent program was given by the faculty of the Stritch School of Medicine. The panel system of presentation was used and an open discussion followed. Armour and Company, which is located two miles north of Kankakee, invited the physicians to tour their plant the morning of the conference. The attendance was augmented by this fact. Lunch was served by Armours. All physicians who made the inspection of the plant were impressed by the modern equipment, cleanliness and excellent care used in the manufacturing of products. The conference this year was most successful and the best attended in the past ten years.

There seems to have been an unusual number of fifty-year certificates this year. All of the counties have had one or more presentations, particularly DuPage County which had five. This is the most that has been given in any county in this district since the beginning of the presentation. It is a privilege and a pleasure to present the fifty year pins and certificates to these men even though many of them are friends of years standing and it is difficult to believe they have attained that age.

It is a pleasure to report the Woman's Auxiliary has become most active this past year. We now have units in all but two counties. Your Councilor has attended

all the meetings of the Council and the various committees of which he is a member. The cooperation he has received from the officers of the county societies has been most helpful and greatly appreciated. He wishes to thank the officers individually for their cooperation this past year. Your Councilor wishes to thank the officers of the Illinois State Medical Society for their cooperation.

It is with regret that I report the death of Dr. Rikli of DuPage County. He was secretary of that society for thirty-five years. He was a most worthy and reliable secretary and a friend of years.

Respectfully submitted, E. S. HAMILTON, M. D., *Councilor, Eleventh District.*

THE SECRETARY: Dr. Hamilton has apparently had one of the rare virus infections. He has been indisposed for two weeks. I propose to get in touch with him later in the day to see what his condition is. He called me last week and at that time thought he would be able to come in the latter part of the week.

#### **REPORT OF COUNCILOR-AT-LARGE**

##### **LEO P. A. SWEENEY, CHICAGO**

Your Councilor-at-Large leaves the office with many pleasant memories and with full appreciation of the cooperation and sincerity of those who guide the Illinois State Medical Society.

It has been a privilege and an honor to have been aboard.

Respectfully submitted, LEO P. A. SWEENEY, M. D., *The Councilor-at-Large.*

#### **REPORT OF THE EDITORIAL BOARD AND JOURNAL COMMITTEE**

During the past year the Journal Committee and the Editorial Board have had six meetings. The work of the combined committees has been shown in the many improvements in the format and the Departments now being published in the Illinois Medical Journal.

One color for the cover of the Journal was used to complete the year of 1953. At the beginning of the year 1954 a major change was made in the method of binding the Journal. The publication had been wire stitched "saddle back" for many years. This made it difficult to include some advertisements in color which were furnished without additional cost to the Journal. To make this possible, the procedure to stitch through the side was begun with volume 105 in January, 1954. Another advantage is that when the Journals are put in the library or upon the shelf one can tell from the back of the magazine the Volume and Number as well as the date. This is of considerable help in reference work.

The addition of more color pages in the advertisements not only brightens up the appearance of the periodical but gives added attractiveness.

The improved quality and weight of paper made the printing of halftones much clearer. Details are more clearly delineated which is a real advantage especially in the photographic reproduction of pathologic specimens.

The quality of the articles published and the ads accepted for publication has elicited many complimentary comments.

The editorials have been of a high order touching on many of the questions which were discussed in the Journal or which were of up-to-the-minute interest to the profession.

Sections devoted to Pathological Conferences, Medical Economics, News of the State, and Know Your Society have been timely, contributing additional interest to the various issues of the Journal.

The practice of having all papers read by one in the specialty in question has been continued and, in some instances, several doctors have been asked to read a paper and criticize the content. This has helped to make the final product clearer and more readable.

Just because a paper is returned to the author is no sign that it does not contain meritorious material. More often this is done because the article is written with long, involved sentences. Frequently the clarity of meaning has been neglected.

In the coming year it is hoped that meetings of the Committee can be held at least every quarter and that persons particularly interested in some phase of the publication of the Illinois Medical Journal will either ask to be heard at such meetings or that they will send in their communications to be acted upon. We would like to have the Illinois Medical Journal the best in the nation. Only with the help and suggestion of the rank and file of the doctors in the state will this end be accomplished.

We would like to give proper credit to those who have helped to make the Journal what it is today, the editors, Dr. Harold M. Camp and Dr. Theodore R. VanDellen, to Mr. Ed Malley, the business manager, who through his untiring effort and his contacts has made this Journal a rarity by keeping it in the black with at least a slight profit. Mr. James Leary has also given valuable help in suggestions from his wealth of newspaper knowledge to raise the standard of the issues of the Journal. The department editors have also in their quiet way added much to the value of the magazine to the general practitioner.

Grateful acknowledgement goes also to Dr. Willis I. Lewis, President, and to Dr. F. Lee Stone, Chairman of the Council, who so willingly approved recommendations of the Editorial Board and Journal Committees.

Respectfully submitted,

HARRY M. HEDGE, M. D., *Chairman*. JOSEPH T. O'NEILL, M. D., ALBERT VANDERKLOOT, M. D., JOHN LESTER REICHERT, M. D., PAUL P. YOUNGBERG, M. D., R. C. OLDFIELD, M. D., *Journal Committee*, JAMES H. HUTTON, M. D., *Chairman*, JOSIAH J. MOORE, M. D., EDWIN M. MILLER, M. D., JACOB E. REISCH, M. D., JOHN R. WOLFF, M. D., FREDERICK H. FALLS, M. D., RAYMOND W. McNEALY, M. D., EDWARD F. WEBB, M. D., ARKELL M. VAUGHN, M. D., EDWIN F. HIRSCH, M. D., KELLOGG SPEED, M. D., *Editorial Board*.

## REPORTS OF STANDING COMMITTEES

### COMMITTEE ON MEDICAL SERVICE AND PUBLIC RELATIONS

In general, the last year has been the busiest yet for the Committee on Medical Service and Public Relations and its staff. The work-load shows no signs of decrease, as more and more county medical societies establish public relations committees and programs and turn to us for advice and assistance, and as the complexities of modern medical public relations problems and techniques multiply. However, we believe that this increase in demand is an extremely encouraging sign, indicating that Illinois medicine is approaching the solid front essential to success in the battle against Socialism.

The principal development as far as staff is concerned was the resignation of John W. Neal as our legal counsel and legislative representative as of January 1. Mr. Neal's long and effective service with this society deserves sincere praise from us; his departure is a severe loss. By order of the Council, responsibility for recommending a successor was placed on this Committee; a number of candidates have been interviewed, but as this is written, no final decision has been made.

One secretary, Mrs. Julia E. Milner, left in December to reestablish her home in Louisiana when her Marine husband returned from Korea.

### GENERAL DATA

The Committee has held six meetings since our last report to the House of Delegates as of April 1, 1953.

Since that date, the office of the Committee has prepared, mimeographed and mailed a total of 48 news releases to newspapers, radio stations and television stations, some to the state as a whole, some to a limited area. Eleven of these were for the state society, eleven for the Chicago Medical Society, five for the Woman's Auxiliary, and twenty-one for the Committee on Postgraduate Education.

In addition, four reports of various sizes, prepared by Mr. Neal and dealing with our legislative problems, were handled and mailed under his direction during the 1953 session of the Legislature.

Further, the office has also handled various reports and letters dealing with the work of the Committee, of the Postgraduate Committee, of the Secretaries' Conference, etc., a dozen or more in all.

These figures represent an increase of about 80% over last year in the total quantity of material issued. It should be added that a score or so of other writing tasks, speeches, articles for the Illinois Medical Journal, special letters and the like, also fell to the lot of the Public Relations office. Mr. James C. Leary, our director of public relations wrote and mimeographed a series of ten skits or playlets, each illustrating vividly some phase of medical public relations at the direction of Maurice M. Hoeltgen, M. D., secretary of the Chicago Medical Society and chairman of the Secretaries' Conference for dramatic presentation under Jacob E. Reisch, M. D., of Springfield, at the Conference April 4.

In addition our director of public relations attended the American Medical Association meetings in New York and St. Louis, our own annual meeting, the Clinical Conference of the Chicago Medical Society, the American Medical Association Public Relations Institute, the American Medical Association Legislation Committee Conference, ten of the thirteen major postgraduate conferences, and delivered an address on medical writing before the American Medical Writers' Association in Springfield. He also went to Decatur when the first gamma globulin mass inoculation was staged there, at the request of local officers; the event was locally so well planned, however, that there was little left for him to contribute. Further, he has attended all meetings of the Council and more than 35 committee or other small evening meetings having to do with the work of the Society in one way or another.

As we have pointed out in previous reports, the work of this Committee differs from all other committees of the Society, in that its general function touches that of many other committees, which are limited to one or two specific functions, and our services are available on call to any committee or to any component society. This occurs often in ways sometimes not clearly public relations; but, since we are also a committee on medical "service," there seems to be no circumscribed limit to our potential interest. Moreover, we welcome all demands for service from any source and feel it both a duty and privilege to fulfill them to the best of our ability for the good of medicine as a whole.

Finally, our public relations office has continued through the year to handle the mechanical details of setting up our postgraduate programs under the direction of George A. Hellmuth, M. D. Over the months, this activity imposes a substantial burden, but, because it is well spread out and because it is well organized, it has been possible to absorb it without undue difficulty.

Before passing on to some of the details of our activities, we have two other things to say. First, we want to extend our thanks to Harold M. Camp, M. D., our state secretary, even though he is a member of this Committee, for the unfailing cooperation and helpfulness his office has always extended to our public relations office. His experience and knowledge have often cleared the way or prevented mistakes, and Mrs. Frances C. Zimmer, his executive assistant, has given likewise indispensable help when needed.

Second, we want to ask of every member of the House of Delegates, as well as every officer of the state society and of the component county societies, an ever greater level of interest and activity in the work of this Committee. Public relations and legislative representation are not functions that can be delegated to a committee and forgotten. They require the active cooperation of every society and every individual member at all times. Our staff cannot perform these functions. All they can do is use their experience and contacts to organize and bring to bear the weight of influence of the medical profession in the community, and that means individual participation by every member. If

medicine is to win its fight against Socialism, the real enemy of the profession and of our country as we know it, every one of us must give all he can of time, energy, experience and personal influences. Each delegate and each councilor should take that message back to his home society and keep hammering it home.

#### THE PUBLIC RELATIONS PROGRAM

We have continued, despite many new and interesting activities, to keep driving ahead at our main purposes—the promotion of medical public relations programs in Illinois, and the maintenance of suitable medical representation before the Legislature. Let us turn to the public relations program first. It has several aspects:

1. **THE P. R. PAMPHLET.** The full title of this pamphlet, written by Mr. Leary, is "The Public Relations of County Medical Societies: Outline of a Program." It was made available in a tentative mimeographed form at the public relations dinner during the 1953 annual meeting and later mailed to all county societies not represented at the dinner. All recipients were asked for critical comment and several suggestions were received and incorporated. Then a final draft was prepared and last autumn printed in pamphlet form.

It aroused much gratifying interest. Apparently it filled a deeply-felt need. The American Medical Association took enough copies to send out in its "PR DOCTOR" service, a P. R. idea exchange which goes to all medical P. R. executives. As a result, ten states asked for additional copies, New York, Georgia and West Virginia for enough to supply all their county societies. Others wanted to reproduce it for their own use, while still others used it as a basis for similar pamphlets of their own. The American Medical Association assigned a writer to do a similar pamphlet. The American Dental Association also asked for copies.

Meanwhile, the printed form was sent to the president and secretary of every county society in Illinois and of the branches of the Chicago Medical Society, with an invitation to ask for more copies if desired. Many have done so, including Winnebago, Clinton, Jackson, Jersey, Knox, LaSalle, Macon, Macoupin, McHenry, McLean, and Menard at last count.

We believe that this pamphlet is a basic and important service, in that it reduces to a relatively brief outline, with notes, the elements of a county public relations program. It provides a basis by which the inexperienced physician may maintain a proper perspective in the flood of ideas constantly being thrown at him, and by thus simplifying the program it also acts as a stimulus to his own P. R. thinking. Its acceptance across the country shows how badly it was needed, and Illinois is happy to have provided this service.

We intend, with the approval of the Council, to maintain this pamphlet in circulation, bring it up to date as required, and using it as the basis for our program of stimulating P. R. activity in every county and by every individual member. We invite any comments and suggestions for improving it to that end.

2. **THE P. R. PAGE.** In October, 1953, we began to

publish each month in the Illinois Medical Journal a P. R. Page. This is intended as a medium of exchange of ideas, a bulletin board on public relations ideas, a record of the activities of county societies, a forum for discussion of public relations policies, programs and philosophy, and a general source of stimulation and education in public relations. It is written in our office, with contributions from various county societies and suggestions from Dr. Camp, Dr. Hopkins and others.

We hope that officers and the P. R. chairmen of every county medical society especially will continue to follow this column and to contribute news, ideas, suggestions and criticism in order to develop its full value potential. Like the P. R. Pamphlet, this column's value can be measured only by the degree of its utility at the grassroots level.

3. **PERSONAL P. R. CONTACTS.** At the direction of the Committee, Mr. Leary has been making personal contacts with county society officers and chairmen throughout the state. The purpose of this activity is to interest county societies in looking over their own P. R. problem and of undertaking the required program. He has been able to combine this activity with the post-graduate programs, since each program usually brings together representatives of numerous societies roundabout. His services are available on call to any society desiring help or suggestions.

It is difficult to evaluate this activity, because there are numerous other factors operating toward the same end. However, it usually takes several pressures from different directions to galvanize an inert group to action, and his visits serve as at least one of these pressures. We believe the program is worth while. He has talked to representatives of all the larger county societies downstate, some of them several times. The fact is that most of these societies, some of them dead spots PRwise a few years ago, are now working out P. R. programs.

4. **P. R. DINNER.** The Committee is also responsible for the annual public relations dinner during the annual meeting. The purpose is to bring together P. R. chairmen or other officers responsible for P. R. activity in each component society, and present speakers on various phases of P. R. work, and give opportunity for questions and discussion. Last year some 65 attended the dinner. This year we hope that a much larger number will attend and represent more societies.

5. **OTHER PAMPHLETS.** The Committee has also directed Mr. Leary to prepare two other pamphlets. One will deal with rural medical care in Illinois, and will replace the still used "Doctors and Horses," one of the most popular pamphlets on the subject yet produced, which has been re-edited and re-issued five times. This work is well in hand and the pamphlet will be available for distribution at county and state fairs this summer. It will, of course, be submitted for approval to the Committee on Rural Health, of which Dr. Harlan English of Danville is chairman.

The second pamphlet will deal with health care insurance, and will be for general lay distribution to

stimulate interest in all forms of insurance. This work has been held up by the resignation of Mr. Neal, whose advice was deemed necessary, but it will be completed shortly. In general, this pamphlet points out the importance of health insurance and tells how to go about selecting and buying it.

These two pamphlets, together with the County P. R. Outline, will round out our present pamphlet program.

6. **P. R. QUESTIONNAIRE.** There is no requirement and consequently no system by which county medical societies report to the state society on their public relations activity. Obviously some test of the P. R. status of the state is needed, to evaluate our present and future programs and correct them, and to adapt them to changing situations.

It is our intention, therefore, following the P. R. dinner during the forthcoming annual meeting to prepare and distribute to county medical societies a questionnaire covering certain key P. R. activities described in our pamphlet. The answers obtained will give us a measure of the P. R. activity level throughout the state and enable us to direct our efforts more specifically to weak points.

7. **SUMMARIZING:** The broad outlines of our public relations program for Illinois are made clear we believe, in the foregoing six headings. Our function is primarily to act as a goad or catalyst to procure public relations activity in the doctor's office and in the county society, where it is most effective and most essential. Second, we conceive it as our function to do what is necessary at the state level, such as supplying speakers, issuing news releases and other statewide approaches to the public mind, procuring or preparing printed and other material. Next, we supply advice and consultation on P. R. problems to any individual or organization to help keep them out of trouble and to find solutions for their problems. The various activities outlined above are directed to these ends. We have no way and no idea of compelling any individual or group to accept or act on our suggestions. Instead, we try to convince every member that maintaining good public relations is part of his duty to himself, his profession and his community, and then we offer him help in carrying out what he decides his own personal situation requires.

#### OTHER ACTIVITIES OF THE P. R. OFFICE

In what follows we have confined our descriptions to the major and continuing programs with which we are involved, omitting the dozens of miscellaneous single chores which are performed by the P. R. office. These programs represent and illustrate the administration of the functions referred to in the last paragraph.

**THE AMBULANCE PROGRAM.** At the behest of Dr. George A. Hellmuth of Chicago, our public relations director has given much time and energy to the work of the Joint Emergency Ambulance Committee sponsored by the Institute of Medicine of Chicago and approved by the Chicago Medical Society and the Illinois State Medical Society. Dr. Hellmuth is chairman of

the Committee. Mr. Leary has been made a member of the Committee, which includes lay representatives of labor, hospitals, city officials, as well as medicine. He has attended a series of meetings with the mayor, police, fire and health officials of Chicago, outlined a program of activities, including a survey of emergency hospital admissions, and written a summary interim report which is now on the Mayor's desk.

The purpose of the Committee is to persuade the city of Chicago to establish an adequate emergency ambulance service in Chicago. Currently 47% of emergency patients arriving at eleven major hospitals arrive in private cars or taxis, 24% in police cars, 22 afoot and 7% in a suitable modern ambulance. It seems reasonable to assume that establishment of an adequate public service through the leadership of the medical profession would be conducive to better public relations, since it would be a real public service, benefiting all people.

**THE WOMAN'S AUXILIARY.** The Committee stands ready at all times to help the Woman's Auxiliary, in the firm belief that it is one of our best public relations agencies. Our office is thus often called on to render the ladies some assistance, usually in the form of publicity for their programs and other activities. Thus it has prepared and mailed five releases to press, radio and television on their annual meetings, and on the monthly programs in Chicago, as requested. We also helped set up a county fair exhibit for the Kankakee Auxiliary, and arranged the special speakers, both for Kankakee and for the St. Clair Auxiliary. In two instances, because of other contacts, we have been able to suggest likely areas for the formation of new county auxiliaries where previous attempts had failed, but circumstances had changed.

While we are on the subject, we take this opportunity to express our deep appreciation for the work of the Auxiliary and to urge every county society which is numerous enough to give serious consideration to the need and value of such an organization. Only the refusal of permission by the medical society is preventing the formation of several additional county auxiliaries. In view of our need for all the allies we can gather, it is suggested that such decisions might be reviewed to determine if the reasons for them are still valid. The Woman's Auxiliary has given us outstanding and decisive help on several occasions and, generally speaking, deserve all our thanks and support.

**CHICAGO MEDICAL SOCIETY.** Our office has also devoted considerable time to the Chicago Medical Society, acting whenever requested or directed by its officers. The public relations director attends its monthly Council meetings to handle any press problems arising from its work under the supervision of its officers. Thus he operated a press room for the science writers covering the annual Clinical Conference in March, and helped in publicizing the meeting in advance acting for Dr. Walter C. Bornemeier, president, and conference publicity chairman. He has given some time and issued two news releases to promoting use of C. M. S. Doc-

tors' Emergency Service, acting for Dr. Robert R. Mustell, committee chairman.

In two instances, he wrote and issued statements in the name of the society defending medical men against unwarranted attacks by political office holders. One was in the case of the Woodlawn Hospital, where a seven-page mimeographed statement was used to blanket Cook County with medicine's side and was well received. It was the same story with a short statement protesting against a sweeping criticism of all doctors for the sins of a few during an investigation of illegal abortions. Each served its purpose in defending the profession and sounding the warning that medicine is ready and able to strike back promptly and vigorously when unjustly attacked or when politically motivated individuals try to use it as a convenient whipping boy.

Our office also publicized widely the new child poisoning control program worked out on a trial basis in six Chicago hospitals. This was at the direction of Dr. John L. Reichert.

**OUTSTANDING GENERAL PRACTITIONER.** We also publicized as usual the selection of the outstanding general practitioner for Illinois for 1954—Dr. George Allen Dicus, 90-year old Streator veteran. Two news releases, with pictures, were distributed throughout the state, and we also prepared an elaborate detailed biography of Dr. Dicus, which was bound as usual into a loose-leaf book of cellophane sheets, along with many letters from his Streator friends and fellow-practitioners, and it was submitted by Dr. Camp as our entry for the national title.

**THE INTERPROFESSIONAL COUNCIL.** This is another activity to which we have been able to contribute some assistance. We were able to help in revising their constitution, now complete and in planning their program. This is an activity which we commend to every delegate with the suggestion that he promote it within his own society. Currently, dentistry, pharmacy, chiropractic, optometry and veterinary medicine are aligned with medicine at the state level in this Council. Its purpose is to create closer cooperation for the benefit of all among the healing arts groups through joint scientific and social association, in political and other fields. It is a group of great promise.

The outline of the public relations phase of our Committee's activities could be easily lengthened. We could talk of our work with Dr. Jacob E. Reisch and Dr. Willard W. Fullerton on the state fair exhibits, of the work with the group seeking to establish a medical museum, of the publicity program for our own annual meeting, of the help given to various departments of the American Medical Association, including the legislative alerting system, and so on. But we believe we have presented a sufficiently broad picture to indicate the ever-growing load that is carried by our public relations office.

#### GOVERNMENTAL AND LEGISLATIVE

When this committee's report was written a year ago, the Illinois legislature was in session, and several important pieces of medical legislation had not by that time been disposed of. Senate Bill No. 73, which

would have cleared the way for osteopaths to practice medicine and perform surgery in Illinois, had been defeated in committee, but other important medical bills were not finally disposed of until late in June.

As a result of the bitter controversy surrounding the osteopathic bills, two separate proposals were made in the Legislature to investigate the Medical Examining Committee of the Department of Registration and Education. House Resolution No. 77, introduced by Rep. Noble V. Lee, called for the creation of a nine member committee of the House to investigate "the manner in which medical schools are accredited by the Department of Registration and Education, and to investigate the delegation of powers by, the methods and personnel of, and the conduct of examinations by," the medical examining committee, and also "any direct domination of said examining committee by any medical society or association." This resolution was referred to a committee, but no hearings were held, and it was never reported to the House of Representatives for action.

Meanwhile, Senate Bill No. 434 was introduced by Senators Everett Peters and Walker Butler, proposing the creation of a ten member legislative commission "to study problems relating to the granting of limited licenses under the Medical Practice Act and to determine whether the Medical Practice Act is being administered in accordance with the intention of the General Assembly as expressed in said Act." This bill passed both houses of the legislature, but was wisely vetoed by the Governor, who in his veto message stated, in part: "It is clear that the study proposed in this Bill can and should be undertaken by the Department of Public Health and the Department of Registration and Education." The Governor also pointed out that the Bill carried a \$20,000 appropriation for expenses, and that such an expenditure is not justified.

In the field of tuberculosis control and eradication, several important bills were passed, and two were vetoed. Senate Bill No. 221, which would have enabled local health authorities to compel open T. B. cases to accept hospitalization, was vetoed. So also was Senate Bill No. 290, which proposed the creation of a special legislative commission to investigate all phases of the tuberculosis problem in Illinois. Several other T. B. bills supported by the Illinois State Medical Society were passed and approved. Senate Bill No. 291 increased the annual tax levy for the Chicago Municipal Tuberculosis Sanitarium to \$5½ million for 1954 and 1955, and to \$5¼ million for subsequent years. Other bills: increased the size of the Cook County Tuberculosis Sanitarium board from three to five members; authorized the hospitalization of non-residents in state financed T. B. hospitals; increased the amount of state-aid to local T. B. authorities from \$3.00 to \$4.00 per patient per day; and permitted county boards to vote the excess T. B. tax for an indefinite period, rather than for a maximum of ten years.

The perennial effort of the Palmer School of Chiropractic to qualify its graduates was again defeated, but

only after a hard and bitter battle. A bill which would have required physicians to report cases of blindness to the Illinois Department of Public Welfare was vetoed.

But the noisiest and most highly publicized medical matter to come before the legislature was "Krebiozen." Limitations of space permit that story to be told only briefly in this report. Prior to March of 1951, Dr. Andrew C. Ivy, who was then Vice President of the University of Illinois in charge of the University's Chicago Professional schools, and was and is Distinguished Professor of Physiology in the U. of I. College of Medicine, had been conducting research on a substance which he felt showed promise in the field of cancer control. The substance, later named "Krebiozen," was brought to him by Dr. Stevan Durovic and Mr. Marko Durovic, originally of Yugoslavia and later Argentina. In March of 1951, for reasons too involved to be stated here, Dr. Ivy called a meeting at the Drake Hotel to report on the work done and progress made. The gathering was a mixed one, and included some physicians, numerous laymen and a considerable number of science writers and newspaper reporters and photographers.

Out of that meeting came a tremendous amount of sensational publicity about a "cancer cure," and an enormous demand for "Krebiozen" was created over night. As a result of that meeting, Dr. Ivy was tried and convicted by the Chicago Medical Society on charges of unethical conduct, and in November of 1951 he was suspended for a period of three months. Later, he elected to let his membership lapse, and he is no longer a member. It will be recalled that Dr. Ivy was removed as vice president of the University of Illinois, and a highly publicized controversy ensued between him and Dr. George Stoddard, then President of the University.

These events prompted the legislature to create, largely at the instigation of Dr. Ivy and his associates, a joint committee to investigate the entire matter, particularly as it pertained to the University of Illinois. Several loud and unruly hearings were held, at which a long list of associations and individuals were accused of conspiring to either steal or throttle Krebiozen by discrediting or ruining Dr. Ivy and his associates. The A. M. A., the Chicago Medical Society and Dr. Josiah J. Moore of Chicago were included in the list of alleged conspirators.

It soon became apparent to the legislative committee that they could not possibly complete their investigation before June 30, 1953, at which time the legislature would adjourn, so they gave a preliminary report and suggested that an interim Joint Legislative Commission be created to conclude the investigation and report back to the next General Assembly in January of 1955. This was done, and \$10,000 was appropriated to defray the commission's expenses.

Marathon hearings ensued, at which Mr. Neal served as counsel for the Chicago Medical Society. Before the hearings ended (which occurred before any of the alleged conspirators were given the opportunity to pre-

sent any evidence), more than 8,000 typewritten pages of testimony were taken, and many hundreds of documents were offered in evidence. Most of the commission members, as well as fourteen lawyers representing the various parties in interest, sat through more than forty hearings, some of which lasted from 10:00 A. M. to 11:00 P. M. The explosive charges and counter-charges of conspiracy, fraud, fakery, threats of kidnapping and death were reported extensively in Chicago and other newspapers, and the repercussions travelled most of the way around the world. The cost of the proceeding to the taxpayers of Illinois, and to the various persons and associations involved is impossible to determine, but could easily be a quarter-million dollars or more.

The net results of this long, costly and futile proceeding cannot immediately be appraised. Although the Commission's preliminary findings absolved all parties—accusers as well as the accused—of any wrongdoing, legal, ethical or moral, great harm has undoubtedly been done. The scientific reputations of a great university and several members of its faculty have been gravely injured. The public has read and reread many times serious—though baseless—charges against organized medicine and numerous prominent and respected physicians. It is difficult to see what recommendations the Commission could make to the legislature which could possibly undo to any extent the harm which has thus far been done.

In the Nation's Capitol there is greater interest and activity in the field of health legislation than ever before. The offices and staff of the American Medical Association's Washington office have necessarily been enlarged to handle the increased work load. Much of the health legislation now pending is highly controversial, supported by the professional "liberals" and opposed by more conservative elements. Many of the latter are finding it increasingly difficult to distinguish (except for the labels used) between the health proposals made by this administration and the previous one. To list but a few of the important measures pending:

1. Federal "reinsurance" (subsidization) of private medical and hospital care plans.
2. Extending social security to include virtually everyone, physicians also.
3. "Broadening" social security in many respects, including the incorporation of a disability insurance program.
4. Medical care for the dependents of military personnel.
5. Military medical scholarships—federal aid to medical education.
6. More liberal income tax deductions for medical expenses.
7. Broadening federal-state unemployment compensation, so that employers of one or more persons (now eight or more) would have to file returns and pay tax.

It is quite evident that legislation in the field of health—local, state and national—will become increasingly important in the years immediately ahead.

In conclusion, we must express our deep appreciation to all those members who have contributed time and energy to the improvement of the public relations of the medical profession. Without their help obviously our efforts would be futile. And we say to all those who have not yet come to realize the importance of this program that we hope it will not be long before they help make it a solid front for medicine's fight against Socialism.

Respectfully submitted, PERCY E. HOPKINS, M. D., *Chairman*, EDWIN S. HAMILTON, M. D., EVERETT P. COLEMAN, M. D., LEO P. A. SWEENEY, M. D., E. A. PISZCZEK, M. D., *Ex-Officio*: WILLIS I. LEWIS, M. D., HAROLD M. CAMP, M. D., *Advisory*: JAMES C. LEARY, *Director of Public Relations, Committee on Medical Service and Public Relations*.

#### MEDICO-LEGAL COMMITTEE

No official meeting of the Medico-Legal Committee was held during the fiscal year.

Three matters were referred to the committee:

CASE No. 1:

This case was referred back to the appropriate county medical society since a dispute was one between a member of the county medical society and a local hospital board.

CASE No. 2:

This case involved a *locum tenens* contract in which one member of the contract was in the armed services. Since this was a civil contract the physician was advised to seek professional legal counsel.

CASE No. 3:

This case involved the filling out of an inquiry on the status of medical liability insurance in the State of Illinois from the State of New Jersey. The desired information was obtained and forwarded.

Since no further business was referred to the committee for action this completes the report of the Medico-Legal Committee for the fiscal year.

Respectfully submitted, GEORGE C. TURNER, M.D., *Chairman*, A. L. NICKERSON, M. D., PLINY R. BLODGETT, M. D., F. E. BIHSS, M. D., EDWARD C. HELFERS, M. D., RALPH McREYNOLDS, M. D., *Medico-Legal Committee*.

#### COMMITTEE ON ARCHIVES

The members of your Committee on Archives have met on three occasions during the past year while attending meetings of the Committee on Medical History. Methods of collecting and preserving items of historical interest have been discussed. Letters have been sent to all Societies indicating the various types of material needed. Since Volume II of The History of Medical Practice in Illinois covering the 1850 to 1900 period is practically completed, collection of historical data pertaining to the years following 1900 is now in order. However anything of importance occurring before 1900 is also requested.

Preparation of these Volumes required a great deal of planning, reference work and research. Well kept records makes the task much easier and insures accu-

racy. The John Crerar Library, 86 East Randolph Street, Chicago 1, Illinois, has been designated as a depository for our Archives. Please send historical articles to Miss Ella Salmonsens who is keeper of our Archives at that address.

Respectfully submitted, TOM KIRKWOOD, M. D.,  
*Chairman*, J. J. MOORE, M. D., *Secretary*, E. H. WELD, M. D., DAVID J. DAVIS, M. D., *Committee on Archives*.

#### COMMITTEE ON MEDICAL EDUCATION AND HOSPITALS

As of 1953 the State of Illinois had 318 hospitals supplying 71,023 beds—of these 253 are general hospitals, 31 hospitals for tuberculosis, 10 hospitals for the chronically ill and 24 are for mental patients. The estimated need of hospital beds in this state in 1953 was 105,651. This estimate is arrived at by allowing 4.5 beds per thousand population for general hospitals, 2.5 times the average annual deaths from tuberculosis in the state over the most recent 5 year period for tuberculosis hospitals, 2 beds per thousand population for chronic disease hospitals and 5 beds per thousand for mental hospitals. It is apparent that while Illinois provides 75.8% of needed beds for general hospitals, it only supplies 46.7% of needed beds for mental hospitals.

Of the 318 hospitals in the State of Illinois, 114 are run by non-profit associations and 88 are wholly or practically managed by or thru some church affiliation. The state government and the Veterans Administration assume almost all the responsibility for housing and treatment of the mentally ill. Together they provide between 53 and 55,000 beds. The city, county and state appear to carry most of the burden of caring for the tuberculous. There are 17 hospitals providing 1,136 beds purported to be used as convalescent hospitals. It appears as tho the time for considerable expansion in this area is long overdue. Another area that should be expanded is in the field of chronic diseases. Hospital beds for the care of the convalescent and for the chronically ill can probably be added and maintained at far less cost than is necessary for general hospitals. There is much data to support this view and further the patients probably could receive better and more sympathetic care. At present practically all these beds are furnished at the county level. Two private hospitals supply 320 beds for chronically ill and one hospital of 272 beds takes only incurables. There are a few small scattered hospitals that limit themselves to children, cardiac disease, eye, ear, nose and throat, alcoholism, industrial medicine and physical medicine. The need for some of these specialties, operating as distinct and separate units, might well be questioned.

The cost of building and operating hospitals is probably at an all time high. The anticipated construction costs for building a new hospital ranges between \$8,400 and \$28,400 per bed depending upon the number and type of embellishments desired. The average cost is in the neighborhood of \$16,000 per bed. Federal and state aid to community as outlined by the Hill-Burton Act had been a great help. Originally the communities were

only required to guarantee 50% of the total cost of the hospital. This figure has since been raised to about 66%. Since the Hill-Burton Act came into effect in 1949, 43 hospital construction projects have been built or are in the process of being built in the State of Illinois. Twenty-nine of these projects have been completed. Of the 43 projects 7 are in the Chicago area and the rest are scattered thruout the state. The total expenditure involved in these 43 hospital projects amounts to some \$60,000,000 of which \$19,000,000 came from the federal government and \$8,500,000 came from the state. New hospitals constructed and completed in the Chicago area last year are the Louis A. Weiss Memorial Hospital, 116 beds, Resurrection Hospital, 180 beds, LaGrange Hospital, 100 beds, two V. A. Hospitals, 500 beds each, and Chicago State Tuberculosis Sanatorium, 400 beds. Downstate has witnessed the opening of several new hospitals.

The cost of operating a private hospital is estimated at about \$23 per diem per patient. Of the total operating cost of a hospital, 60 to 65% goes into salaries. Hospital administrators state that it requires 1½ employees per patient to adequately staff a hospital. Because of the increased skill required to carry out some of the newer technological procedures, more and better trained personnel are required. Cost of food and supplies have increased but not to the same degree as salaries.

The 68th Illinois General Assembly passed a bill that was signed by the Governor in July, 1953 providing for the licensing of all hospitals. Previously only Hill-Burton hospitals and maternity hospitals were required to be licensed. The law is to be administered by the State Department of Public Health. The only hospitals that will be exempt from licensing under this law are state and private mental hospitals and psychiatric sections of general hospitals, which are already licensed by the Department of Welfare. The hospital licensing board provided for by this law will consist of two members of hospital governing boards, three hospital administrators and two practicing physicians. This board must approve all rules or regulations before their adoption by the Department of Public Health. The act has not yet been put into effect, but plans for its administration are being formulated.

In an attempt to improve hospital care there has been formed a joint commission on accreditation of hospitals. This commission has the support of the American College of Physicians, The American College of Surgeons, The American Hospital Association, The American Medical Association and The Canadian Medical Association. The director of the commission is Dr. Edwin L. Crosby who maintains headquarters in Chicago. The efforts of the commission are purely voluntary and are expended in an effort to improve the standards of hospital care thru a system of self evaluation.

In March, 1954 the joint commission released its annual list of accredited hospitals in the United States, its possessions and Canada. Of the 7,500 hospitals in

these areas, the commission gave full accreditation to 2,920 hospitals and provisional accreditation to 298. In the State of Illinois 161 hospitals have been fully accredited and 22 have been provisionally accredited. Of the 161 accredited hospitals 76 are in Cook County and of the provisionally accredited hospitals 3 are in Cook County. Provisionally accredited hospitals are those from whom full accreditation is withheld until certain defects have been corrected. Any hospital over 25 beds desiring to qualify may so notify the commission and in due time their facilities will be inspected.

The commission interests itself first of all in the physical plant, paying close attention to safety factors particularly those related to fire protection. The aim of the commission further is to set up and apply certain basic principles of organization and administration. These principles are designed to promote efficient care of patients by assuring them the greatest possible benefits that modern medical science can offer. Hospital administration interests the commission particularly in determining the part played by the staff in governing the hospital. Organization of the staff under a sound workable constitution which permits and encourages staff responsibility in matters pertaining to hospital operation is essential. Medical staff meetings and where possible departmental organization and meetings are considered necessary evidence of proper staff interest and participation in hospital affairs. An active conscientious tissue committee that reviews all tissue removed at operation is considered a vital and important factor in staff function. This committee must be made up of staff members who have sufficient stature to expose irregularities and insist upon their correction. Medical records are reviewed by the commission to determine the adequacy of the history, physical examination and progress notes. They insist on records being documents that can be intelligently reviewed by anyone long after the patient has been discharged. The commission feels that all staff appointments no matter where they originate should be officially approved by the staff or its governing body. Limited terms of appointment allow more flexibility of the staff and are encouraged but not required by the commission. However tenure of staff position during good behavior and ethical conduct will make for greater stability than annual reappointment as is now practiced in many hospitals.

NURSES

The shortage of nurses is more apparent than real and results largely from a poor distribution. Thus in 1952 there were 12% more nurses, 72½% more part time general duty nurses and 8% more full time general duty nurses than in 1948. During this period there were 9% fewer nurses engaged in private duty nursing. In 1948 there were 6.2 beds per professional nurse in all hospitals while in 1952 there were 6 beds to each nurse. Stated in another way there were 5.3 patients per nurse in 1948 and 5.1 patients per nurse in 1952. From these statistics it is obvious that the number of trained nurses is increasing proportionately with the hospital and patient load. Because nurses are not distributed according

to hospital beds, there will be some areas in which there is a marked shortage. Furthermore because 88% of nurses work in general hospitals where 41% of beds are found, and only 5% work in Psychiatric hospitals where 48% of hospital beds exist, there is a real shortage in the field of psychiatric nursing. Actually in general hospitals there is one nurse for 3 beds while in psychiatric hospitals there is one nurse for 59 beds.

Nurses engaged in public health work are gradually increasing as are also the number of government agencies employing nurses. Local boards of education account for 49% of all the government agencies employing nurses. Industry now utilizes the services of 4.3% of all active professional nurses. There is an increasing demand for industrial nurses as more and more industries provide some form of in-plant medical services. The armed forces in 1953 claimed the services of 10,299 nurses.

The nursing situation in the State of Illinois as of 1951 can be appreciated by examination of the following table.

Total number of nurses .....	36,259
Active nurses .....	21,240
Inactive nurses .....	15,019
Male nurses .....	571
Non-white nurses .....	749
Nurses working in hospitals or training school ..	13,477
Public Health nurses .....	1,221
Industrial nurses .....	1,338

Taking the figure 103,214 as the number of hospital beds and bassinets in the 342 hospitals reported to the A. M. A. as operating in Illinois during 1952 and the figure 21,240 representing the active nurses, it is apparent that there was a nurse for every 5.1 hospital beds.

However, since only 13,477 nurses were working in hospitals, the figure was actually 1 nurse for 8 beds. Even this figure does not appear too bad. Yet when one considers that nurses can choose their hospital employer it is obvious that some hospitals may have adequate nursing coverage while others remain woefully understaffed. Increasing the number of nurses without proper distribution will not completely solve the problem.

The wage scale for private duty nurses in Chicago is \$15 for the eight hour day shift and \$16 for the evening and night shift. This scale fits into the present day wage structure so far as the individual nurse is concerned, but to the patient requiring 24 hour nursing care the financial strain of \$47 a day is a factor to be considered. Obviously private duty nursing has become a luxury that few can afford. It would seem that segregation of the very sick patients and some form of special group nursing is worthy of further study.

The wage scale for general duty nurses in Illinois varies from \$250 to \$300 a month. This is about \$100 to \$150 a month less than a nurse is able to make at private duty. Nevertheless the enforced layoffs without pay incident to private duty nursing seems to make general duty more attractive. It is worthy of note

that the wage scale in private hospitals is approximately equivalent to that in government hospitals. The latter do supply fringe benefits that seem to make them preferred.

A serious defect in the wage structure of nurses lies in the slight differential between the general duty nurse and supervisors. The latter have usually had advanced training, possess practical experience, assume great responsibilities and yet receive but a few dollars a month more than the most recent graduates. This undoubtedly causes many excellent nurses to seek a more profitable outlet for their talents.

A problem confronting nursing administrators has arisen from the present trend of allowing nurses to administer intravenous fluids. Nurses are not satisfied that their legal right to administer any type of intravenous therapy has been properly clarified.

There are 82 schools of nursing operating in the State of Illinois. Of these 33 are in Chicago. Alexian Brothers Hospital conducts a school of nursing for men and Provident Hospital has a training school for Negroes. Of the 82 schools in Illinois 31 state they will admit Negroes and 14 admit male students. In 1952 there were 2,850 students admitted to training in Illinois and 2,054 students were graduated.

In 1953, 102,019 students were in the 1,148 schools of nursing in the U. S. Since 1951 there has been a 38% increase in students enrolled in degree programs. Less than 1% of students enrolled were male and 4.1% were non-white.

The practical nurse and the auxillary worker arose and prospered as a supposed solution for the shortage of registered professional nurses. In the decade prior to 1949, the practical nurse and auxillary worker entered the hospital picture to the extent that by 1949 they exceeded the number of registered nurses working in hospitals. By 1952 there were 70,000 fewer registered professional nurses than non-professionals in hospitals registered with the A. M. A. The meteoric increase in non-professionals in hospitals has resulted in an overall increase of nearly 30% in the number of individuals caring for the hospitalized ill since 1948.

Statistics compiled in 1952 reveal that at that time in the State of Illinois there were employed 1,910 practical nurses, 6,690 attendants, 5,948 nurses aides, 978 orderlies, and 1,107 ward maids. There are 4 practical nurse training programs operating in Illinois. The length of the course as prescribed by law is 9 months.

#### MEDICAL SCHOOLS

For the fourth consecutive year the number of students applying for admission to medical schools has decreased. In the U. S. the freshman class of 1953-54 had about 2,085 fewer applicants than the classes one year earlier and almost 10,000 fewer than the freshman class of 1949-50.

Yet in spite of the decrease in number of applicants, there are still more individuals seeking admission to medical school than the schools are able to accept. The capacity of medical schools is limited by their physical plants and the funds to support them. Because of this limited capacity, applicants usually apply to more than

one medical school. Thus there were 3.3 applicants in 1953-54 for each place in the freshman class.

In Illinois the Chicago Medical School processed 936 applications for 72 freshmen, University of Chicago School of Medicine 804 applications for 72 freshmen, University of Illinois Medical School 509 applications for 166 freshmen, Northwestern 1,431 applications for 128 freshmen and Stritch School of Medicine 688 applications for 88 freshmen. It will be noticed that the University of Illinois processed the smallest number of applicants for the largest enrollment of freshmen. This results from the fact that state schools in general are forced to take the majority from their own state. Because of this limitation in their choice of students, state controlled schools are forced to take some students whose medical college admission tests have been in the lowest quarter and in some schools even the lowest 10%.

#### INTERNSHIP

There continues to be a shortage of internes and residents. It is difficult to determine what factors play the most important part in influencing medical students in their choice of an internship. It would seem that the following factors must enter their thinking: 1) Salary; 2) Teaching facilities; 3) Possibility of obtaining a residency; 4) Rating of an internship by previous interne groups from each school; 5) Likelihood of being able to obtain staff privileges when internship is completed; 6) Physical comforts and social opportunities offered and 7) Working conditions including time off, vacations and so forth. Just what consideration prospective internes give to each of the above is impossible to ascertain, but hospitals, by outbidding each other with attractive salaries, would seem to be focusing their attention on remuneration rather than education.

The growing demands of the various specialty boards are without question a factor in the unequal distribution of internes because the young physician who wishes to limit his practice must have a board certificate and the smaller hospitals cannot get recognition for their training programs.

Since we as a people are so certificate minded it might be well if the medical schools took over and added to their curriculum an additional course that would cover what is now being attempted by the hospitals.

The hospitals' staff specialists then could take the men who wished the association on a preceptor basis.

The logical sequence then would be for the state to license specialists, after a searching examination has demonstrated their qualifications to act as consultants and to handle the difficult, complicated, and rare cases that present themselves to the general man or to the man who is limiting his practice to a certain field.

For the past three years internships have been largely distributed thru the hospital matching plan. There are in the United States about 10,726 available internships. As of July 1, 1954, 6,051 graduates will have secured internships. There will be 4,675 internships that cannot

be filled by graduates from American schools. The matching system is sponsored by the Association of American Medical Colleges. Each senior student chooses three or four hospitals in the order of preference and sends his application to the Association. At the same time an application and a transcript of the student's credits are sent to these hospitals. The hospitals then review their applicants' records and send the Association a list of these applicants in the order of their preference. At the headquarters of the Association, the prospective intern and hospital applications are matched. On a stated date both the student and the hospital are notified as to the outcome of the matching. Both the student and hospital agree to abide by the results of the matching plan.

The shortage of American trained interns has been partly compensated for by an influx of foreign-born graduates. Because of language difficulties and in some cases, poor medical training these foreign trained interns have failed to provide satisfactory or adequate solution of the intern problem. Hospitals therefore have no assurance from year to year that they will have all or even a part of their intern quota. Consequently it is difficult and seemingly useless in many instances to sponsor and maintain adequate intern training programs.

Residency programs are also in a constant state of flux, because of the continued threat of military service. Some hospitals will not accept a non-service man, and most hospitals give preference to service men. This is understandable when one realizes that a non-service resident may be abruptly inducted into the armed services at almost any time. A residency program requires stability and continuity. Without these factors the residency becomes a few months extra internship.

However, the best hospital training program cannot turn out a finished product to the field of medical practice. Furthermore, it is doubtful whether the hospital, even though it be a teaching hospital, should be expected to furnish formal education. As was said by Dr. G. V. Black, "The professional man must be a continuing student."

In conclusion, to render the best possible medical care at the lowest cost to the patient, requires the close cooperation between an alert and active staff and the hospital management.

Respectfully submitted,

GEORGE F. O'BRIEN, M. D., *Chairman*. HARLAN ENGLISH, M. D., K. L. VEHE, M. D., *Committee on Medical Education and Hospitals*.

#### COMMITTEE ON MEDICAL BENEVOLENCE

Your committee has worked diligently, and we believe, fairly with each case under consideration. We hope that our efforts are appreciated by all those receiving aid from the Benevolence Fund.

The financial condition of the Committee is ample at this time to take care of all requests for assistance. It has always been my hope, and the hope of many interested in the work of this Committee, that this Fund become large enough that the income from

investments could take care of the necessary payments. One year ago by action of the House of Delegates, the five dollars from the dues was reduced to only two dollars. While this amount is ample now, there may come a time when an increase may be necessary.

There are 27 people receiving various sums from the Committee: of this group ten are physicians. The other recipients are widows or other dependents of former members. Six recipients passed away during the year, and one was removed from the list as no longer needing assistance. The Committee has four requests for assistance being processed at this time.

During the year there have been several instances when the Council of the Illinois State Medical Society has appropriated more money for individuals than the maximum allowed by the Committee. In one instance this action was taken by the Council without the knowledge of the Committee, and the Committee feels that any increase in payment should be made only upon the request of the Committee and with the knowledge of the Committee members.

Taking into consideration the fact that the value of the dollar has decreased almost to half of its former value, we are of the opinion that the minimum amount for a recipient of assistance should be at least fifty dollars a month and the maximum not over seventy-five dollars.

The Committee again wishes to thank the Woman's Auxiliary for its cooperation and its contributions to the Benevolence Fund since the last annual meeting. During the current fiscal year the Woman's Auxiliary has contributed \$5,510.68 to the Fund.

During the recent illness of the chairman, Dr. Oscar Hawkinson, formerly a member of the committee, was kind enough to serve in this capacity. The Committee wishes to extend official appreciation and thanks to him.

Respectfully submitted,

ROBERT H. HAYES, M. D., *Chairman*. LEE O. FRECH, M. D., NORMAN L. SHEEHE, M. D., *Committee on Medical Benevolence*.

#### COMMITTEE ON MEDICAL TESTIMONY

It is with more than usual pleasure that we are able to report that during the past year no complaint of irregular or dishonest testimony in our courts or other hearing bodies has been received by our Committee.

Respectfully submitted,

OSCAR HAWKINSON, M. D., *Chairman*. EVERETT P. COLEMAN, M. D., WALTER L. PALMER, M. D., HARRY A. OBERHELMAN, M. D., EDWARD H. WELD, M. D., ARTHUR F. GOODYEAR, M. D., JOHN H. GILMORE, M. D., MAURICE T. HORSTMAN, M. D., *Committee on Medical Testimony*.

DR. OSCAR HAWKINSON: Since the report of the Committee on Medical Testimony was prepared we have received one complaint about the expert testimony of one of our members. This is now being processed. Premature bragging is to be deplored.

### GRIEVANCE COMMITTEE

During the past year there were three meetings of the Grievance Committee. A fourth was cancelled because four of the members of the Committee were ill.

Three cases were disposed of with no action necessary. It was found that most of the trouble was the misunderstanding of the parties making the complaints.

The remainder of the complaints came to the Committee without first being submitted to the local committee of the county society. Consequently these complaints were returned to the secretaries of the respective societies for local action. Each was told that after local action the complaint could be returned to the state committee for further consideration if deemed necessary. The six cases thus referred in error to the State Committee were, through local action, disposed of to the satisfaction of all parties concerned without further deliberation of the State Committee.

One case brought to the attention of the Committee was settled by a civic court action before the Committee needed to take any steps.

I think this report verifies the efficacy of this manner of handling the physicians and the public who feel that their rights are being transgressed and who wish a means for airing their feelings and correcting the errors thus caused.

Respectfully submitted,

HARRY M. HEDGE, M. D., *Chairman*. C. PAUL WHITE, M. D., PERCY E. HOPKINS, M. D., E. H. WELD, M. D., T. G. KNAPPENBERGER, M. D., EDWIN F. BAKER, M. D., *Grievance Committee*.

### REPORT OF DELEGATES TO THE A.M.A.

Since our last meeting, the House of Delegates of the American Medical Association has met twice. All of the delegates from Illinois were present at these meetings.

At the New York meeting, many interesting things occurred. The president, Dr. Bauer, reported his experiences. Dr. Bauer expressed the opinion that too little attention has been paid to the teaching of ethics and traditions of medicine to the younger generation of doctors. The establishment of courses of instruction for new members of County Medical Societies was recommended.

Dr. Bauer was shocked to know how many members of the American Medical Association know little or nothing about their own organization.

The president-elect, Edward McCormick of Ohio, in his address dedicated himself to the advance of the ethical standards of American Medicine and promotion of the public health and welfare.

The report of the Joint Committee on Hospital and Physician Relationships of the American Medical Association and the American Hospital Association was unanimously approved by the delegates. This excellent report certainly presents a general statement of principles that can be followed in any hospital.

After much more discussion of the care of veterans' problems, the House adopted the following recommen-

dation, regarding VA Hospital care admissions:

- A. Veterans with peacetime or wartime service whose disabilities or diseases are service incurred or aggravated, and
- B. Within the limits of existing facilities, veterans with wartime service suffering from tuberculosis, psychiatric, or neurological disorders of non-service connected origin, who are unable to defray the expenses of necessary hospitalization.

The House recommended that new legislation be enacted limiting veterans' care to the above two groups. As you well know, the results of this and a multitude of other meetings has been to cause the Veterans Administration to tighten up slightly on their admission policies. The current Congress is insisting that we wait another year or so to ascertain the effects of this new tightening up of admission policy before any type of legislation will be considered. The American Medical Association's Committee on Veterans' Care is making every effort to disseminate as much information as possible on the total problem of veterans' care to the constituent state societies.

One of the most controversial matters that came before the House during the New York session was the report of the Committee for the Study of Relations Between Osteopathy and Medicine. The hearings on this committee report were packed. The discussion before the House was intense. Majority and minority reports were submitted by the Reference Committee. The final action of the House was to defer until June, 1954 any definite action. In the interval, each state association should answer and report its answers to its delegates on the following questions:

1. Should modern osteopathy be classified as "cultist" healing?
2. Since the objectives of the American Medical Association include improvement in under-graduate and post-graduate education, should doctors of medicine teach in osteopathic schools?
3. Should the relationship of doctors of medicine to doctors of osteopathy be a matter for determination by the several state associations?

It is apparent that after these questions are answered by the 48 states, and the answers transmitted to their State Delegates to the A. M. A. a better answer to this problem will be effected. Without any question, one of the most controversial matters before the June, 1954 session of the House of Delegates will be the answers to these questions.

Mrs. Oveta Culp Hobby, the Secretary of the Department of Health, Education, and Welfare, addressed the House of Delegates concerning the position of the Eisenhower administration in general health matters.

The late Dr. Elmer Henderson, in his report on the American Medical Education Foundation, paid the highest type of tribute to our state. Illinois led the entire nation in the total sum of money contributed to the American Medical Educational Foundation by a State Medical Society. The state of Utah has taken up the Illinois program, and other states are seriously con-

sidering it. Illinois can be proud to have set such a high standard of individual responsibility towards the education of our successors and towards a token payment towards our own education.

The report of the Committee on Constitution and By-Laws, in response to requests and numerous communications concerning the principles of medical ethics, reported that no basic changes be made now. One addition was made to the principles at the New York meeting.

The committee recommended, and the House concurred, in concluding the principles with this statement:

"These principles are intended to serve the physician as a guide to ethical conduct as he strives to accomplish his prime purpose of serving the common good and improving the health of mankind. They provide a sound basis for solution of many of the problems which arise in his relationship with patients, with other physicians, and with the public. They are not immutable laws to govern the physician. The ethical practitioner needs no such laws; rather they are standards by which he may determine the propriety of his own conduct. Undoubtedly, interpretation of these principles by an appropriate authority will be required at times; as a rule, however, the physician who is capable, honest, decent, courteous, vigilant, and an observer of the Golden Rule, and who conducts his affairs in the light of his own conscientious interpretation of these principles will find no difficulty in the discharge of his professional obligations."

The Council on Medical Education and Hospitals reported on its revised essentials of approved internships. Because the laws of supply and demand are constantly at work, it is difficult to write essentials for internships that please everybody. It was the committee's view that a more realistic appraisal by individual hospitals of their needs for interns and the lowering of the number of internships offered by hospitals is both necessary and desirable.

The Council on Medical Education and Hospitals also submitted their report on the training of medical record technicians. This problem will increase in magnitude as the volume of clerical work in connection with the sick in hospitals also increases. These essentials may be obtained from the A. M. A. office in Chicago and certainly have broad implications as to our daily practices. The entire House of Delegates concurred in the recommendations of the Council on Medical Education and Hospitals.

The Committee on Blood submitted a very extensive report on the problems of blood collection and distribution in the United States. At the conclusion of this long report and considerable discussion, the House recommended that the Committee on Blood confer not only with the Red Cross but with other interested national professional organizations with a view towards evaluation, at the earliest possible date, of a practical plan for a continuing national blood program. If pos-

sible, this plan should command the general endorsement and support of all segments of our country.

A multitude of resolutions on various subjects were submitted at the New York session. Those concerning the matter of Social Security were summarized with a resolution which indicated that the profession wanted no extension of Social Security to groups not now covered and that no Federal medical or hospital care established under Old Age and Survivor's Insurance be established, and that serious consideration be given to returning to the states responsibility for financing and administering such pension programs as the citizens desire. These recommendations were forwarded to the President of the United States.

In connection with the resolutions concerning the intern matching program, the final decision was that further study be continued on the problem by a committee appointed by the Speaker of the House of Delegates. Half of this committee shall be doctors in the private practice of medicine and not connected with medical schools or hospitals.

Many resolutions were brought to New York concerning Dr. Paul Hawley and some of his public statements. The hearings on these resolutions were extensive. During the course of the extensive hearings before the Reference Committee, Dr. Hawley had his say, and many other groups had theirs. The House of Delegates agreed with the following report submitted by the Reference Committee:

"The principles of medical ethics as formulated, interpreted, and applied by the American Medical Association must be considered the only fundamental and controlling application of ethics for the entire profession. Any statement relating to ethical matters by other organizations within the general profession of medicine advance views of only a particular group and is without official sanction of the entire profession as represented by the American Medical Association."

The Reference Committee reported, and the House concurred, in the belief that the harm done to the public and to the profession by current articles which lower the confidence of patients in their doctors cannot be objectively evaluated. When individuals or groups without official status in the American Medical Association utter or publish ill considered statements, the result too often is that the confidence of the public in the profession is placed in jeopardy. Destructive critical comments serve no useful purpose. The committee reported, and the House concurred, in the statement that the utmost confidence in the great majority of physicians is enjoyed by their patients and that the great majority of the practicing profession need no additional advice from either the Reference Committee or the House of Delegates. Human nature being what it is, it will probably always be true that some doctors violate the principles of medical ethics. The committee reported, and the House concurred, that the method evolved for dealing with the problems of unethical conduct in practices by the American Medical Associa-

tion, while short of perfection, is still the best and most practical means of correcting abuses and safeguarding the best interests of the public. The House concurred in the view that constituent associations must become increasingly vigilant and aggressive in the pursuit and correction of ethical abuses. This continuing need, which is and always will be present, results because doctors are subject to the same weaknesses of the flesh and spirit as are other people.

The House of Delegates of the American Medical Association adopted the Illinois resolution which recommended that other states follow our pattern of \$20 per member per year.

The Illinois resolution concerning amendments to the Constitution and By-Laws, in connection with proper billing, was referred to the Committee on Constitution and By-Laws with the stipulation that they seek the advice of the Judicial Council in consideration of this problem.

Our resolutions on amendments to the Constitution of the United States and the International Labor Organization were affirmed by the House since the House had previously acted on both matters.

The resolution on the compact of the western states for medical education was endorsed by the House of Delegates of the American Medical Association and sent to the Committee on Legislation for implementation. As an aside, it might be said that these resolutions have passed the Congress of the United States and have been signed by President Eisenhower. They are in the process of implementation.

Mr. Louis Gough, the Commander of the American Legion, addressed the House on the Legion's position in connection with veterans' hospital care. Although he was generally critical of the position taken by the physicians of America, he made one great admission: "The American Legion has maintained the closest possible contact with the veterans' medical and hospital system for thirty-five years. We have developed experience in this field, but *we do not know all the answers.*"

Dr. Frank Lahey, in his last address before the House, reported on what men in industry were doing for the American Medical Education Foundation.

The New York meeting concluded with the installation of Dr. Walter Martin as President-Elect.

#### ST. LOUIS INTERIM SESSION

The highlights of the St. Louis Interim Session, December 1 through 4, 1953, were the following.

The House reaffirmed its opposition to compulsory inclusion of physicians in Social Security.

The House urged continued action to obtain the passage of the Bricker Amendment.

The House recommended that the Congress reduce the limitation on the deduction of medical and dental expenses for income tax purposes.

The House reaffirmed its opposition to continuation of the "Doctor Draft Law" beyond June 30, 1955.

The House, as a whole, considered an emergency resolution which again condemned all insurance contracts which classify any medical service as a hospital

service. The resolution went further and reaffirmed our definitions of pathology, radiology, anesthesiology, and psychiatry as medical services. The occasion for the passage of these types of resolutions was the inclusion of medical services in a Blue Cross contract written for the meat packing industry.

Another emergency resolution on Federally subsidized medical scholarships as a mechanism of building up career medical corps for the Armed Services was considered. The House transmitted this complex problem to the Board of Trustees for action and implementation.

Iowa brought up a resolution wanting approval of joint billing procedures by two or more physicians. The House referred this matter to the Judicial Council to determine if there were any new factors that would cause the Council to change its opinion last rendered in 1952.

The House recommended that the rules and regulations of the Joint Commission on Accreditation of Hospitals be widely disseminated in the Journal of the American Medical Association, and the editor agreed to such wide dissemination.

President McCormick advised the delegates to advise all physicians whom they contact that: "Good public opinion can't be bought. It must be earned through exemplary conduct and genuine service in the public interest. Whatever money the A. M. A. and its constituent societies spend for public education and public relations is wasted unless individual physicians take wholehearted interest in assuring the success of these ventures."

Dr. Joseph I. Greenwell of New Haven, Kentucky, an 80 year old practitioner, was awarded the "General Practitioner of the Year" medal. His conduct through many years of practice exemplified the best in the profession.

Dr. Chester Kiefer, the special assistant to Secretary Hobby, made some remarks concerning the problems facing both government and the profession.

Dr. Howard Rusk reported on the American-Korea Foundation Rehabilitation Mission.

The Committee on Credentials, at the St. Louis session, was the busiest in many years of A. M. A. history. The Committee learned that the legality of the transactions of the House of Delegates might be called into question if individuals should be seated and vote, and it should later develop that that person had no legal right to membership and voting privileges. About 12 members of the A. M. A. House of Delegates presented faulty credentials or none at all and could not be seated.

The House of Delegates accepted the following recommendation from the Credentials Committee:

"Hereafter, only those individuals presenting documentary evidence of the right to membership in the House of Delegates be seated.

"That the Credentials Committee be furnished by the Headquarters Office with an official list of delegates and alternates.

"That at least two members of the Credentials

Committee be appointed from the membership of its immediate predecessor."

Many other smaller matters were discussed, but did not have the importance of these affairs.

Respectfully submitted,

HARLAN ENGLISH, M. D.,  
*Chairman, Illinois Delegation.*

## REPORTS OF COUNCIL COMMITTEES

### ADVISORY COMMITTEE TO THE I.P.A.C.

A review of the minutes of the meetings of the State Medical Society's Advisory Committee to the Illinois Public Aid Commission from April, 1953 through March, 1954 reveals that six dinner meetings were held. Representatives of the State Committee have participated, with representatives of the Commission's State Drug Advisory Committee, in three meetings of the Subcommittee on drugs. Nineteen physicians, (including chairmen and members of County Medical Advisory Committees), have been invited to attend meetings of the Committee and to offer their comments and suggestions about policies and procedures affecting physicians and problems arising in their capacity as advisors in the County Departments of Welfare.

The State Medical Advisory Committee has continued to work closely and cooperatively with the Illinois Public Aid Commission by giving advice on general problems arising from the Commission's responsibility for providing medical care of good quality, at reasonable cost, to all recipients of public assistance. Members of the Committee continuously give consultation to the Commission staff on individual case problems when physicians' services, hospital care, drugs, or appliances are involved. The Committee has also fulfilled its function of giving interpretation of the scope and limitation of this tax-supported medical care program to physicians throughout the State.

Problems regarding services rendered to assistance recipients by physicians, and other problems involving the administration of the Commission's medical care program, have been considered by the State Medical Advisory Committee. These questions are referred by Departments of Welfare. Such reports have been reviewed and the problems investigated. The Commission has always accepted the State Medical Advisory Committee's recommendations. This close working relationship between the state public welfare agency in Illinois and the Illinois State Medical Society is in contrast to the situation in many states where medical programs for welfare recipients have been planned and are being operated without the active participation of the medical societies.

The expenditures for medical care for public assistance recipients continued to mount through 1953. The financing of these services out of the funds appropriated by the legislature for all services to assistance recipients has been a serious problem. There is still a difference of opinion as to whether direct payment, (which was inaugurated by the Illinois Public Aid Commission on January 1, 1952), has contributed to the increased medical costs. This method of payment does insure re-

imbursement to physicians for services rendered. It also has certain advantages for the public assistance agency responsible for paying the bills for medical services to welfare recipients by making it possible for the agency to compile information for the obligation for medical care by month of service. Such information was not readily available before direct payment.

Because of the nature of the direct method of payment, all bills are submitted to a central office and such centralization shows the magnitude of the monetary value involved and thus provided for a comparison in the variation of costs from county to county. The very nature of the medical care program makes it necessary for detailed statements to be scrutinized. The agency is able to use statistics in program planning and in developing policies and procedures which will control the quality, quantity, and cost of services to welfare recipients.

It is necessary to emphasize now, more than ever, that the cost of medical care to the Public Aid recipients be kept as low as is consistent with essential medical care. The Commission estimated that it would require about 300 million dollars for this biennium. The Legislature appropriated 273 million. The problem now is to keep within the appropriation. This resolves itself into a few necessary procedures:

First, keep home and office visits to a minimum.

Second, reduce the length of hospital stay consistent with good care of the patient.

Third, reduce the number of drugs prescribed and dispensed and use the less expensive drugs where possible. All charges should be kept within the maximum standards set up by the Commission.

The Commission has had under consideration requests for increases in the rates being paid for hospital care, nursing home care, dental care, drugs and visiting nurse services. However, the Advisory Committee to the Commission has been informed that with no increase in funds the Commission is committed to an economy program and is making no increases, for the present, in the rates being paid for any medical services.

Representatives of the State Medical Advisory Committee were designated by the State Committee recently to meet with a Special Subcommittee of the Commission which had been appointed to study all aspects of providing medical care to recipients.

These representatives met with the Subcommittee of the Illinois Public Aid Commission and found them understanding of the physicians who provide care to assistance recipients, appreciative of the contribution the State Medical Society's Advisory Committee has made over a period of many years in helping to develop and preserve a medical assistance program that will meet the essential needs of recipients, and of the fine cooperation the Commission has had from most physicians in the State.

Among the changes the State Medical Advisory Committee had recommended were:

1. That the amount that may be allowed to physi-

cians for dispensed drugs be increased to cost plus ten per cent:

2. That physicians be allowed to charge up to \$1 per office or home visit for dispensed drugs without itemization except for the names of drugs dispensed.

3. That a list of community prescribed drugs which exceed the Commission's \$3 wholesale cost maximum be prepared by the State Medical Advisory Committee and that physicians be allowed to prescribe or dispense drugs on the list without prior approval. It was proposed that the list of drug exceptions be made available to pharmacists, physicians and hospitals which are participating in the Commission's plan for providing medical services and supplies to recipients:

4. That two changes be made in the quantity standards for physician's visits. The changes recommended were,

a. A change from one visit per month to two per month in home-visits for long term illness.

to six visits in a thirty day period in office visits for

b. A change from five visits in a thirty day period to six visits in a thirty day period in office visits for an acute illness.

As all physicians know, financing of medical services in a public tax-supported program is dependent on the funds appropriated by the legislature. With respect to the request for an increase in the amount allowed for dispensed drugs from five to ten per cent the Commission indicated that since there are insufficient funds for making any increase in the rates being paid for any services no increase could be made in the policy of allowing five per cent for packaging and breakage for dispensed drugs. However, they did agree to the following:

1. That an increase from five to ten per cent in the allowance for dispensed drugs will be made if the funds available for medical care will permit any increases at a later date.

2. That the physicians be allowed to dispense drugs for which the estimated cost is \$1 or less per office visit or home visit without itemization except for the names of the drugs. If the total cost for dispensed drugs is more than \$1, the name, the amounts, and the charge for each drug shall be itemized on IPAC Form SS-132-Physician's Statement.

# EXPENDITURES FOR MEDICAL AND NURSING HOME CARE IN THE CATEGORICAL ASSISTANCE PROGRAMS Monthly Average—July-December, 1953

<i>Type of care</i>	<i>All Programs</i>	<i>Old Age Assistance</i>	<i>Aid to Dependent Children</i>	<i>Blind Assistance</i>	<i>Disability Assistance</i>
ENTIRE STATE					
TOTAL	\$1,936,064.29	\$1,569,904.22	\$156,367.49	\$42,693.42	\$167,099.15
Nursing Home Care	1,012,789.91	869,124.32	2,298.18	23,376.38	117,987.04
Medical Care	923,278.38	700,779.90	154,069.31	19,317.04	49,112.12
Physician's Service	206,384.34	163,827.23	29,086.03	4,211.98	9,259.10
Drugs	146,558.29	119,642.07	14,015.60	3,748.89	9,151.74
Dispensed	56,152.17	46,829.32	5,597.18	1,198.20	2,527.47
Prescribed	90,406.12	72,812.75	8,418.42	2,550.69	6,624.27
Hospital	490,258.84	369,730.97	84,924.23	9,527.20	26,076.42
Other	80,076.91	47,579.63	26,043.45	1,828.97	4,624.86
COOK COUNTY					
TOTAL	831,955.06	629,095.62	86,569.68	17,358.85	98,930.92
Nursing Home Care	496,375.67	398,717.55	1,732.22	10,963.09	84,962.82
Medical Care	335,579.39	230,378.07	84,837.46	6,395.76	13,968.11
Physician's Service	28,176.90	22,019.09	4,371.08	540.33	1,246.40
Drugs	28,808.53	23,676.85	2,946.83	733.89	1,450.96
Dispensed	4,095.65	3,360.32	482.33	76.36	176.64
Prescribed	24,712.88	20,316.53	2,464.50	657.53	1,274.32
Hospital	234,815.53	161,653.37	60,356.99	4,155.22	8,649.95
Other	43,778.43	26,028.76	17,162.56	966.32	2,620.80
DOWNSTATE COUNTIES					
TOTAL	1,104,109.23	940,808.60	69,797.81	25,334.57	68,168.23
Nursing Home Care	516,410.24	470,406.77	565.96	12,413.29	33,024.22
Medical Care	587,698.99	470,401.83	69,231.85	12,921.28	35,144.01
Physician's Service	178,207.44	141,808.14	24,714.95	3,671.65	8,012.70
Drugs	117,749.76	95,965.22	11,068.77	3,015.00	7,700.78
Dispensed	52,056.51	43,469.00	5,114.84	1,121.84	2,350.83
Prescribed	65,693.25	52,496.22	5,953.93	1,893.16	5,349.95
Hospital	255,443.31	208,077.60	24,567.24	5,371.98	17,426.47
Other	36,298.48	24,550.87	8,880.89	862.65	2,044.06

3. That some important and commonly used drugs which exceed the \$3 wholesale price maximum may be prescribed or dispensed without prior approval. The list of exceptions has been prepared by the State Committee, and mailed to each physician in the State.

In agreeing to these exceptions in the drug policy the Commission stipulated that it will be necessary for *physicians* to obtain the approval of the County Department *before* prescribing or dispensing drugs which exceed the \$3 wholesale price maximum and which are not included on the list of exceptions. When approval is given the physician will make a notation to this effect on the prescription. When the need for a drug is emergent at night or when the County Department Office is closed the physician may order the drug and notify the County Department of this action on the next working day.

The Commission has decided that policies with respect to prescribed drugs will apply also to dispensed drugs and to those drugs ordered for recipients in hospitals. (Cortisone, ACTH, and Butazolidin which now require the approval of the State Committee except when recommended as a life-saving measure or for certain eye conditions).

In order to insure a uniform drug policy and to eliminate delays in providing drugs to recipient-patients, the special list of drugs prepared by the State Medical Advisory Committee has been made available to participating pharmacists, participating hospitals and County Departments.

The fourth recommendation made by the State Medical Advisory Committee recommended and which the Illinois Public Aid Commission agreed to put into effect will simplify procedures. This should bring about better relationships between the Illinois Public Aid Commission and physicians participating in the Commission's medical care program and lighten the burden of work of the local County Medical Advisory Committee.

The statistics as listed below should be of particular interest.

Respectfully submitted, B. E. MONTGOMERY, M. D., *Chairman*, CHARLES P. BLAIR, M. D., HAROLD M. CAMP, M. D., JOSEPH W. COMPTON, M. D., HARLAN ENGLISH, M. D., EDWIN S. HAMILTON, M. D., JULIUS H. HESS, M. D., WILLIS I. LEWIS, M. D., F. LEE STONE, M. D., THEODORE R. VAN DELLEN, M. D., *Advisory Committee to IPAC*.

#### **ADVISORY COMMITTEE TO VETERANS ADMINISTRATION**

The last year has seen the reorganization of the Veterans Administration, initiated July 1, 1953. In its course, the department of medicine and surgery became an autonomous unit, headed by the chief medical director who is responsible only to the Administrator of Veterans' Affairs.

At the same time the medical division of the regional office, which is the agency with which we have contact, became the outpatient service of the Veterans Admin-

istration's new West Side Hospital. The service moved its offices to the hospital at 820 South Damen Avenue, Chicago 12.

Lee H. Schlesinger, M. D., manager of the hospital, now in over all charge of the service, asks that requests for service be directed to the out-patient service at the hospital, and to the attention of the particular unit involved, such as fee basis unit, prosthetic, hospitalization, etc.

With this change, the home town medical care service, made available for service-connected disabilities on a fee basis, which is our principal function, goes on as before. No special problems have arisen and the Committee has held no meetings during the year.

During 1953, the out-patient service authorized 18,018 treatments or examinations in home towns on a fee basis for 9,173 veterans. During the same year Veterans Administration staff physicians cared for 55,933 veterans.

The fee basis contract with the Illinois State Medical Society resulted in the payment of \$90,661 to participating members for these services. The comparable figure for 1952 was \$114,788.

Civil hospitals, general, neuropsychiatric and tuberculosis, received total payments of \$99,857. Home visits by nurses totalled 291, a slight increase.

Dr. Schlesinger, in reporting these activities, said that the response of our members to requests that the time rules be observed in asking for authorizations has been most satisfying.

"We feel," he concluded, "that the cooperation of the participating members, the veterans' affairs committee and the officers of the Illinois State Medical Society continue to keep this program outstanding in rendering home town care to our service connected veterans."

For our part, we are happy to compliment Dr. Schlesinger and C. H. Ogden, M. D., who has had charge of the program on their friendly consideration and cooperation in making this contract work out satisfactorily to all concerned.

Respectfully submitted, PERCY E. HOPKINS, M. D., *Chairman*, F. LEE STONE, M. D., LEO P. A. SWEENEY, M. D., CARL F. STEINHOFF, M. D., HAROLD M. CAMP, M. D., *Advisory Committee to the Veterans Administration*.

#### **ADVISORY COMMITTEE TO THE UNITED MINE WORKERS**

The smoothly functioning character of the United Mine Workers of America Welfare and Retirement Fund is attested by the relative infrequency of complaints by participating physicians and the evident increasing satisfaction of recipients of the Fund. The officials of the local unions have apparently arrived at a definite understanding of their duties and of their obligations not to exaggerate the covering of the Welfare Fund and this step in a better direction is quite welcome by the participating physicians in numerous localities where the great inclination was to throw everything in the lap of the physician and to expect

him to explain the recipient's rights. It is our feeling that this educational program, while not complete among the union representatives, has at least been greatly improved in the past twelve months.

The committee has undergone numerous personnel changes in the past year and all concerned miss the familiar face of the genial and capable former chairman, Dr. E. P. Coleman, under whose jurisdiction the committee had its inception and under whose guidance it has become an instrument of almost automatic efficiency. Many new names appear on the list of members of the committee and it is a pleasure to report that the subject matter of meetings has aroused sufficient interest that full membership quota is the usual finding at each gathering and every single item on the agenda is discussed very thoroughly. Our relationship with the Area Administrator, Dr. Cecil A. Z. Sharp, has been most amicable and the disposition of medical problems arising from time to time has been generally stimulated by the intelligent understanding of Dr. Sharp and the key men in the Area Administrator's office, one or more of whom (always physicians) are invited participants in the meetings of the committee.

It has been stressed on all occasions by the Chairman that in no sense of the word does the duty of membership on the committee entail the obligation of sitting in judgment on any of our fellow practitioners. The Welfare Fund seems well able to handle its own business administration and to promote understanding and good will among the participating physicians. Here and there deletions have occurred because of continued infractions of rules. The function of the committee does not include approval of these occasional deletions but appropriate advice is forthcoming whenever it is requested. We feel rather strongly that our serious obligation to organized medicine is to promote understanding and friendly relationship between this immensely successful welfare organization and our own profession and to advise the Welfare Fund of organized medicine's attitude towards problems of mutual interest which of necessity come before the committee for discussion. As further evidence that our committee is functioning efficiently we offer the observation that it was found necessary this year to have only three meetings. The Illinois State Medical Society will be host to a breakfast meeting of the committee the first day of the 1954 meeting in Chicago.

It has been a policy of the United Mine Workers of America Welfare and Retirement Fund to institute new proceedings almost annually whereby the welfare of their recipients is enhanced and to discontinue policies which have proved to be unnecessary or overlapping by another agency. While the Fund has recently made some changes regarding the eligibility of dependents for the medical care and hospitalization services of the Fund, there have been no changes made in the provision of services for those who remain eligible. The Fund has recently limited the eligibility of widows to a period of one year immediately follow-

ing the death of the worker. Each eligible member or widow is provided with an eligibility form listing the member or widow's name and the names of all dependents eligible for service. New forms are issued periodically at which time the older forms become invalid.

The medical care and hospitalization program of the Fund has now been in operation long enough that it is quite well understood and accepted by the physicians, hospitals, and beneficiaries of the Fund located in the coal mining areas. The Fund has had occasional complaints from physicians and hospitals who rendered a service expecting to be paid by the Fund, only to learn later that they could not be paid by the Fund because the patient was not actually a beneficiary of the Welfare Fund. The patient must prove his eligibility by presenting an eligibility form. It is the patient's responsibility to either pay his doctor or hospital bill or prove his eligibility for services at the expense of the Fund.

There had been no change in the medical and surgical care of recipients which includes complete coverage in all cases when hospitalization is necessary. The Welfare Fund is to be congratulated on its rehabilitation program which progresses very nicely and which has been instrumental in the re-employment of many disabled miners with a great improvement in their morale.

We are very pleased to state that the majority of physicians participating in the Fund's medical care program are satisfied and the patients are likewise satisfied. The lot of the miner has been ameliorated medically and the Fund has pioneered in the field of labor-medical relationships. The plan actually gives the patient a reasonably free choice of physicians and hospitals located in his home community. There is in actual practice no disturbance of the time honored doctor-patient relationship. He either gives the patient what, in his own judgment, is necessary or refers the patient for consultation to one of the specialists participating in the program.

Spot checks by the Area Medical Office have shown that on the average, Fund beneficiaries are remaining in the hospital approximately 25% longer than the average length of stay by other patients treated by the same physicians in the same hospital. It is the primary responsibility of the attending physician to discharge patients whose hospitalization is paid by the Welfare Fund when hospitalization is no longer essential to the care of the patient. In one instance it was found that the Fund patient remained in a given hospital exactly twice as long as the average length of stay for all patients in the same hospital. It has also been found that a considerable number of beneficiaries for whom hospitalization is not essential are cared for in the hospital at Fund expense.

On February 21, 1954, your committee adopted the following resolution: "That the committee go on record urging hospital administrators and hospital medical staffs to review their records of hospital

admissions and length of stay, and take the steps necessary to reduce the overall length of stay for Fund patients. The Area Medical Office should send a complete statistical analysis on the hospital admissions for Fund beneficiaries to the administrator with the record broken down for each individual physician. A separate copy omitting the names of all physicians except the one to whom the letter is written should be sent to the participating physician."

It does not appear to us that there will be a final solution to this problem until all attending physicians accept the full load of responsibility for the patients' care and until human nature changes to the extent that recipients of Welfare Benefits fail to insist on the proverbial mile where a reasonably long inch has been offered.

Respectfully submitted, W. A. MONAGHAN, M. D., *Chairman*, B. E. MONTGOMERY, M. D., W. W. FULLERTON, M. D., J. W. TIDWELL, M. D., A. R. BRANDENBERGER, M. D., J. A. MATHIS, M. D., *Advisory Committee to United Mine Workers*.

#### **ADVISORY COMMITTEE ON MILITARY AFFAIRS**

The Advisory Committee has been kept very busy for the past year even with the cutback in calling physicians to service.

We have been kept busy reviewing the cases of all people in priorities I, II and III, making sure the Armed Forces and the Local Selective Service Boards were kept advised on the current availability or essentiality of all individuals.

In reviewing our files, we tried to find how many of the people previously declared essential could be made available.

Last June the Advisory Committee again talked to the graduating medical school students in order that they might be informed of the liability for service. 337 of the graduating senior students filled out the Advisory Committee's questionnaire prior to the graduation, which indicated where they were to be located on their internship training.

The Advisory Committee requested the deferment or essentiality of approximately 165 of the graduates for their internship period. We have now recommended the availability of these individuals in order that the Local Boards may process them for service.

We have materially reduced the cases of essential residents within the state and only those who are found critically essential by the Central Panel and confirmed by the National Advisory Committee will be recommended as essential after July, 1954.

We find that we still have a few priority I and II individuals essential as teachers or research personnel. These cases will be forwarded to the National Advisory Committee for review in order that we may have as many of these individuals declared available as possible.

This Committee has spent some time in an effort

to determine whether or not we should enter into the project of maintaining emergency records on all physicians of all ages with the state. We have been requested by Washington to maintain such a file. It has been established, however, that it would be impossible for our State Committee to maintain such records inasmuch as we do not have the help, nor do we have the funds to finance such a project. We also find that if funds were made available to finance this project, it would be impractical to store the records in Chicago because in the event of a catastrophe the records would surely be destroyed. To maintain them outside Chicago would mean the addition of another employee, which is impossible.

The Advisory Committee will continue working on the cases of physicians within the state and has again spoken to the senior medical students who are graduating in June, informing them of their liability for service.

It might be well to mention at this point that the fate of the Advisory Committee is not known beyond 1 July 1955 inasmuch as the Doctor Draft Law and the Advisory Committee under the Universal Military Training and Service Act as amended expires at that time.

Respectfully submitted, CARL F. STEINHOFF, M. D., *Chairman*, LEO P. A. SWEENEY, M. D., JAMES MAJARAKIS, M. D., F. GARM NORBURY, M. D., HAROLD M. CAMP, M. D., *Advisory Committee on Military Affairs*.

#### **COMMITTEE ON BLOOD BANKS**

During the year there was no committee meeting since there was no business referred to the committee for action. Several problems acted upon last year and referred for action to The Illinois Association of Blood Banks are currently being studied by that group. The items under consideration are:

1. Standardization of blood bank techniques throughout the state of Illinois.
2. Voluntary inspection of blood banks in cooperation with the State Department of Public Health.
3. A state wide system of blood credit exchanges which might be integrated with a National Program.
4. Coordination of local blood bank policies with Regional Red Cross Programs.

Next year we expect several recommendations from The Illinois Association of Blood Banks which will require action by the Illinois State Medical Society.

Respectfully submitted, COYE C. MASON, M. D., *Chairman*, W. A. HAUSE, M. D., BENJAMIN MARKOWITZ, M. D., PAUL A. VAN PERNIS, M. D., GERSHON K. GREENING, M. D., SIDNEY LEVINSON, M. D., PAUL D. REINERTSON, M. D., ROBERT F. SHARER, M. D., *Committee on Blood Banks*.

#### **COMMITTEE ON CANCER CONTROL**

Since internal cancer develops with such few and insidious symptoms the need for expending time,

effort, and money on cancer is paramount. Research continues but advancements are slow from the standpoint of finding a cure. Perhaps the most important research contribution of the year is the discovery at Memorial Hospital, New York, that mercaptopurine will definitely prolong life in leukemia.

The work of the Committee on Cancer Control of the Illinois State Medical Society is closely correlated with the Illinois Division of the American Cancer Society and the Cancer Division of the State Department of Public Health.

Dr. John Rogers continues as Director of the American Cancer Society, Illinois Division and has submitted information below concerning activities of the Division.

Last year slightly over one million dollars was collected in the state of Illinois in support of cancer. Of this sum, 34.7 per cent was devoted to research, and 15 per cent assigned to the National office. Thirteen per cent was spent on public and professional education, 26 per cent on service, 2.6 on administration and 9 per cent on the fund raising campaign. The latter expense is by no means a loss because during the campaign an enormous amount of public education is achieved; this is extremely important because of the necessity to have patients come to the physician at an earlier date.

The Division provided financial assistance to six diagnostic clinics and nine cancer clinics in the amount of \$36,728. In accordance with policies established the year previously, the Division did not provide financial assistance to any cancer detection centers. Two cancer detection centers closed during the year, leaving only one now operating in the whole state of Illinois.

"Twenty-three visiting nurse associations in Illinois received a total of \$21,676. Downstate the visiting nurse service is financed on a cost-per-visit basis. An outright grant of \$4,000 was made to the Visiting Nurse Association of Chicago.

"It will be recalled that the Division financed the printing of a brochure developed by the Committee on Cancer Control of the Illinois State Medical Society for a seven-point examination for the detection of accessible cancer. A convenient file card for the physician was made available on request, free. This brochure was mailed to all physicians in Illinois and returns indicated that 460 physicians outside of Chicago would cooperate and 705 within the city. This is considered by the Committee on Cancer Control to be a very gratifying response, indicating the willingness on the part of the physician to exert all efforts in the early detection of cancer. The brochure popularizes the slogan, "Every doctor's office a cancer detection center."

"In February 1954, the fourteenth cancer refresher course for physicians was held. The program was reduced from five days to three, and it is believed

that this increased the attendance materially, 55 being present. The complete cooperation of Chicago's medical schools and hospital staffs participating was noteworthy.

"The Illinois Division has continued to mail, free of charge, two professional publications—"CA, A Bulletin of Cancer Progress" and "The Cancer Bulletin"—which are mailed on alternate months. All physicians responding to the seven-point cancer detection examination program, as outlined above, who were not already on the mailing list of the Illinois Division to receive these bulletins have been added. The total now distributed free amounts to 4,250, at a yearly cost of about \$15,000.

"The Illinois Division has a library of six professional films on cancer, all related to early diagnosis. These are available for showing at hospital staff meetings, medical society meetings and to medical staffs.

"The Division operates 23 cancer information centers throughout the state. These centers, under the jurisdiction of county chapters of the Society, provide a vital link between the educational and service programs. They provide excellent service to individuals seeking help for a personal or family cancer problem. Medical advice is not given, of course, and each center is directly supervised by the medial members of the county chapter executive board.

Dr. G. Howard Gowen is Director of the Bureau of Cancer Control of the Illinois Department of Public Health. The activities in this Department may be summarized as follows:

Financial support of cancer diagnostic clinics continued as in the past. One new clinic was opened at Memorial Hospital, Mattoon. There were 4,015 suspect cases examined of which 1,120 proved to be malignant. There were 6,241 follow-ups of previous cases.

Looking ahead to 1955 when the American College of Surgeons will inaugurate its new requirements that approval of cancer programs in general hospitals will require the existence of an acceptable hospital-wide cancer registry, we have been working along this line with those hospitals having State-aided cancer clinics. Registries are now functioning at the following:

Memorial Hospital, Springfield.  
St. Anthony's Hospital, Rockford. ●  
Burnham City Hospital, Champaign.  
Evanston Hospital, Evanston.  
St. Francis Hospital, Evanston.  
Carle Hospital, Urbana.  
Little Company of Mary Hospital, Evergreen Park.  
Sherman Hospital, Elgin.  
Graham Hospital, Canton.

Registries are in the process of being set up at the following:

Passavant Hospital, Jacksonville.  
Methodist Hospital, Peoria.

Through the tissue diagnostic service 3,153 suspect biopsy specimens were examined from medically indigent patients. The number of such tissues submitted runs consistently around 3,000 per year of which approximately one-third prove to be malignant. For the first time exfoliative cytology service was provided for patients unable to pay. There were 85 such examinations made.

For the past three years we have been aiding in the establishment of radio-active isotope diagnostic facilities in selected hospitals in which clinics exist. In two hospitals the projects became self-supporting after a year or so and our funds were withdrawn to support a third project in 1953. As part of this program funds were provided to send one of the radiologists for a two-week training course at Oak Ridge.

In cooperation with the American Cancer Society, the Tuberculosis Association, and the Cancer Committee of the Illinois State Medical Society, we have been attempting to motivate a more concentrated attack on lung cancer. The general aims are: more chest x-rays particularly in men over forty, greater awareness by the public, greater awareness by the physician, more personal urging by physicians that their patients take advantage of chest x-ray services when such units are in the community.

Respectfully submitted, WARREN H. COLE, M. D., *Chairman*, THOMAS C. GALLOWAY, M. D., EDWIN F. HIRSCH, M.D., JOSEPH S. LUNDHOLM, M. D., RUSSELL M. JENSEN, M. D., JAMES MAJARAKIS, M. D., JOSIAH J. MOORE, M. D., J. B. MOORE, M. D., *Committee on Cancer Control*.

#### COMMITTEE ON CRIPPLED CHILDREN'S CLINIC

Crippled Children's Clinics in Illinois continue to function well. They are well organized. Satisfactory hospital connections are maintained so that necessary hospitalization and surgery can be effectively planned and carried out as necessary without prolonged delay. The principal children's clinics are listed.

Those held throughout the State:

1. The Illinois Elks Crippled Children's Commission.
2. Division of Services for Crippled Children, University of Illinois, under supervision of Dr. Herbert R. Kobes.
3. A number of independent clinics which are sponsored by individual County Medical Societies.

#### THE ELKS ASSOCIATION:

Lawrenceville	(1)	Paris	(4)
Robinson	(1)	LaSalle	(6)
Olney	(1)	Galesburg	(4)
Mt. Carmel	(1)	Kewanee	(6)
Carlinville	(1)	Champaign	(4)
Pana	(1)	Freeport	(4)
Taylorville	(1)	Danville	(4)
Canton	(4)	Anna	(1)
Streator	(4)	Carbondale	(1)

Lincoln	(6)	Herrin	(1)
Mattoon	(2)	Murphysboro	(1)
Charleston	(2)	West Frankfort	(1)
Ottawa	(3)	Benton	(1)

It should be pointed out that in towns where only one clinic a year is held the patients can be seen in the surrounding area where clinics are held more frequently; thus, every area is served from 3 to 6 times each year.

Total number of cases: ..... 1,862

Total number of examinations: ..... 2,851

A considerable number of cases in this group of statistics are in the adult age.

#### DIVISION OF SERVICES FOR CRIPPLED CHILDREN, UNIVERSITY OF ILLINOIS

No. Tot.		No. Tot.	
Towns	Clinics At.	Towns	Clinics At.
Peoria	24 1,519	Carrollton	2 117
East St. Louis	16 966	Evanston	6 114
Springfield	12 686	Clinton	2 107
Rockford	12 563	Shelbyville	2 106
Hinsdale	12 568	Centralia	2 100
Bloomington	12 511	Jacksonville	2 94
Alton	8 448	DuQuoin	2 92
Chicago Heights	6 289	Tuscola	2 89
Mt. Vernon	4 236	Casey	2 89
Flora	3 229	Pittsfield	2 88
Quincy	4 214	Anna	2 77
Sterling	4 205	Effingham	1 75
Evergreen Park	6 213	Chester	2 72
Elgin	6 207	Vandalia	1 67
Aurora	6 206	Monticello	1 65
Joliet	6 197	Watseka	2 63
Danville	4 190	Shawneetown	1 57
Cairo	4 175	Metropolis	1 55
Litchfield	3 174	Rosiclare	1 49
Macomb	3 165		
Fairfield	2 142	Total	195 9,798
Salem	2 119		

#### CRIPPLED CHILDREN'S CLINICS CHICAGO AREA

Of the number of Crippled Children's Clinics in Chicago that are known to function, the following are those which respond to our request for information:

#### NORTHWESTERN MEDICAL SCHOOL, MONTGOMERY WARD CLINIC

Clinics held weekly—3.

Approximate number of crippled children per clinic—About 10.

New Patients—467; Old Patients—1,928; Total—2,395.

#### THE UNIVERSITY OF CHICAGO

Clinics held weekly—3.

Approximate number of crippled children per clinic—2-5.

#### MOUNT SINAI HOSPITAL

General orthopaedic clinics—1-2 weekly.

1 weekly Pediatric-Cardiac Clinic.

Average children per clinic—4-5.

#### MERCY FREE DISPENSARY

Clinics held weekly Children seen  
Pediatric-Cardiac—20 children.  
Clinic service to cerebral palsied children—22 seen.  
Orthopaedic handicapped—8 children seen.  
Plastic surgery—2 children seen.

(These figures are approximate)

#### THE CHILDRENS MEMORIAL HOSPITAL

Clinics held weekly—2.  
Approximate number of crippled children per clinic—57.

#### THE CENTRAL FREE DISPENSARY OF WEST CHICAGO

Crippled children made 193 visits to our Orthopedic Clinic in 1953. This department is open three days per week, but practically all of our crippled children are seen on Wednesdays, which would be an average of 3.7 patients per session.

#### UNIVERSITY OF ILLINOIS

Clinics held weekly—9.  
Approximate number of crippled children per clinic—10.

#### MICHAEL REESE HOSPITAL, Babette and Emmanuel Mandel Clinic

Clinics held weekly—3.  
Approximate number of crippled children per clinic:  
Cerebral Palsy—7.  
Orthopaedic—2—11 each clinic.

#### COOK COUNTY HOSPITAL

Total number of clinical visits of children from 12-1-52 to 11-30-53—1,720.  
New cases—271.  
Old and repeat cases—1,449.  
6 Clinics weekly.  
Approximate number of crippled children seen—  
Wednesday 15; Friday 70.

**CRIPPLED CHILDREN'S CLINICS IN CHICAGO.** These clinics all have adequate hospital connections. The majority of them are held in institutions which have medical school associations. They are staffed by qualified Orthopaedic Surgeons who have hospital staff appointments. This arrangement facilitates and augments the proper care of the crippled child from the time he is first seen in the clinic; thru his admission to the hospital, during the operative period and finally thru his post-operative care. Follow-up care later is carried out. Here of course the patient's cooperation is encouraged.

Down State Clinics are held in the majority of Counties and in all sizeable communities. Their accessibility is such that all crippled children can be brought to them regularly. Most of them are held periodically several times yearly.

On December 10th, 1953, your Chairman met with representatives of the Illinois Association for the Crippled, Inc., Executive Secretary, Mr. Chas. H. Moody and Program Consultant, Mrs. E. Jameson. Their main source of funds is from the Easter Seal Campaign. They extended an offer to assist in the rehabilitation of the crippled thru the media of physiotherapy and supervised follow-up care. The members

of the Children's Clinic Committee were in accord in their appreciation of this proposed service by the Illinois Association for the Crippled, Inc.

A meeting of Crippled Children's Clinic Committee was held on the occasion of the meeting of the American Academy of Orthopaedic Surgeons, January 25th, 1954, at the Palmer House. Those in attendance were—Dr. John J. Fahey, Dr. Gerard N. Krost, Dr. Frank G. Murphy, Chairman.

No complaints from local medical societies or from members of the Illinois State Medical Society were received.

A review of the Crippled Children's Clinics, their number and locations, was made. It is apparent that the crippled children in the State of Illinois are adequately cared for.

Respectfully submitted,

FRANK G. MURPHY, M. D., *Chairman*. HERBERT R. KOBES, M. D., GERARD N. KROST, M. D., HUGH COOPER, M. D., JOHN J. FAHEY, M. D., *Committee on Crippled Children's Clinics*.

#### THE EDUCATIONAL COMMITTEE

The Educational Committee held four meetings in the Chicago Office: July 11, 1953, October 17, January 23, 1954 and March 13. Minutes were prepared and circulated to the Committee and the Chairman presented four detailed reports to the Council. The last report was circulated to the Council one week in advance of its meeting.

#### TELEVISION

On June 11, 1953, "How's Your Health," the Committee's weekly telecast, left the air for an indefinite period. This was occasioned by commercially sponsored commitments by WGN-TV, Channel 9. The offer of afternoon time was rejected because the Committee believed the format of "How's Your Health," was designed for family viewing, rather than for a preponderantly women's audience.

Through Dr. George Byfield and the Secretary the Committee has maintained a close personal contact with representatives of WGN-TV and has deliberated carefully the possibilities of commercial sponsorship. Many factors are involved, principally the necessity of the producer of the show, in this instance the Secretary of the Committee, and the moderator becoming union affiliated, and the payment of all participants.

The Committee has promised its cooperation to WTTW-TV, Channel 11, the Educational Station now being developed for Chicago.

"All About Baby," a daily telecast over WBKB, has been serviced by the Committee since its inception on April 30, 1952. In 1953 the telecast became commercially sponsored, first by Mead, Johnson and subsequently by Libby, McNeill and Libby, Swift's Meats and Bell-Howell. In conformity with the Committee policy, the physician scheduled on "All About Baby" one day a week does not appear on the screen

at the time the commercial is given. Because the program is commercially sponsored with all participants being paid, the physician is also paid.

During the year forty-six physicians were scheduled, seven of whom were rescheduled when the telecast left the air for a short time.

A typical reaction by physician participants may be summed up in the following letter: "With hesitancy I accepted your invitation to be present as a 'performer' on the telecast 'All About Baby.' Today, I hang my head in shame because of my family-patient response, and their pleasure in seeing someone they know on television. I am sure preschool children do not know whether or not their pediatrician appeared intelligent or stupid—they just love seeing their doctor. Thank you for giving me this opportunity to please my cherubs."

Since the pioneering effort on television, initiated in 1948, the Committee has reported the interest from other states. This continues. A representative from the Iowa State Medical Society spent three days in the Chicago office to learn the "know how" of experience; one representative from the Essex County (N. J.) Medical Society spent one day, and a representative of WGN-TV on loan to survey the field for WTTW-TV, Channel 11, obtained extensive data on our operations as did the Hartford County (Conn.) Medical Association and the Hartford Department of Health. The University of Michigan School of Public Health uses "How's Your Health" as a teaching experience; the American College of Anesthesiologists requested permission to feature our telecast "Guardians of Your Sleep" at its 1953 Seattle meeting, and a free-lance writer devoted paragraphs to our work in an article on educational television published in the *Delphia Quarterly* in November. One member of the staff of Northwestern University's radio station, WNUR, Evanston, working on a master's thesis, devoted an afternoon to reviewing our experiences with "How's Your Health."

Scripts and other material have been given to the Adams County Medical Society, working in cooperation with the Adams County Department of Health, and to the Winnebago County Medical Society, whose executive secretary spent hours with Miss Fox in pursuit of information.

The Chairman and Secretary met with the Public Relations Committee of the Rock Island County Medical Society in Moline, December 7, 1953, to discuss Committee experiences in television and to assist, if possible, in the development of local programs. The Secretary had a conference with Dr. Ernest McEwen, representing the Institute of Medicine of Chicago, and one with representatives of the Chicago Plastering Institute, outlining Committee policy and development of TV formats.

The Committee wishes to report it has not relinquished its interest in television, nor is it unaware of the creative ingenuity and enthusiasm of the Secretary is not only launching the project originally,

but in producing it for five years. The Committee believes television to be of tremendous importance as a medium for health education and has authorized the Secretary to establish new contacts on another channel.

#### RADIO

Your Doctor Speaks", a transcribed broadcast, has been presented weekly over FM Station WFJL for the past five years. Since the last report forty-nine physicians have written their own presentations at the invitation of the Committee. To obtain a more "conversational" tone to these presentations, the Committee authorized the Secretary this past year to "sit in" at the sessions when the transcriptions were being cut. The opinions of the participating physicians and studio personnel reveal the experiment to be a success.

One radio manuscript, authored by Frederick Stenn, titled "Discovering Lost Gems in Medicine," was considered to be of such excellence that the Committee recommended it be published in the *Illinois Medical Journal*. The editors have accepted it for early publication.

#### SPEAKERS' BUREAU

Ninety-seven physicians were scheduled for speaking appointments to schools, Parent-Teacher Associations, Illinois Federation of Women's Clubs, Lions', Kiwanis and Rotary Clubs, Young Women's Christian Associations, county medical society and hospital auxiliaries, National Safety Council Congress, libraries, nurses, church and other miscellaneous groups. A series of six lectures was arranged for the Maine Adult Evening School.

#### HEALTH TALK

Launched in 1947, the weekly publication *HEALTH TALK* supplanted a one page column "Do You Know." Starting with the then existing mailing list of 342, the total now is 1,061, going in mimeographed form to the weekly press of Illinois, the metropolitans of Chicago, the presidents and secretaries of county medical societies and other state medical associations. Two selected issues, totaling 8,158, are printed and mailed monthly to 4,074 teachers, schools, nurses, hospitals, industrial plants and health chairmen of Parent-Teacher Associations and Illinois Federation of Women's Clubs. The Councilors are on both the weekly mimeographed and monthly printed mailing lists. In addition five individuals, the Egyptian Health Department and the Springfield Tuberculosis Association receive 732 issues for distribution, and eight schools a total of 706. To obviate a duplication and a "dead" mailing list, individuals of some organizations were removed and the required number of *HEALTH TALKS* are sent instead to permanent offices for distribution. Thus sixty-four home advisers of Health Improvement Associations, ninety-six Home Bureau offices of the Illinois Agricultural Extension Services began to receive in April 6,752 copies of *Health Talk*.

During June, July and August, the 910 schools are removed from the monthly mailing list. During the school year, however, a total of 16,340 *Health Talks*

are being mailed the fifteenth of each month for widespread distribution in Illinois.

On September 19, 1953, Arthur Snider, Science writer for the Chicago News, used the issue "Try Laughing," first released in 1949. This issue, incidentally, won seven awards. The same article was featured in Science Digest in December.

Blue Print for Health, Blue Cross publication, used two issues in its Winter Issue: "Earache in Children" and "The Body's Temperature," and one on "Athlete's Foot" in its Spring 1954 issue. Science Newsletter featured three issues the past year as did the National Catholic Kindergarten Review.

During the year 137 persons, representing schools, libraries, schools of nursing and hospitals, requested certain issues in amounts ranging from one to 300. A total of 1,500 of five different issues went to the Illinois Federation of Women's Clubs for a regional downstate meeting, and 250 to the AMA Conference on School Health.

In its effort to tighten up the clerical handling, the Committee asked some schools and industrial plants to mimeograph the story for distribution. A follow-up revealed the project was not working out satisfactorily, but the experiment is being continued for further study, pending the success in the Danville Public Schools where 400 issues were requested.

While every effort is made to make HEALTH TALK available, there is also a concomitant effort to restrict the mailing list to those engaged in health work. The clerical handling of HEALTH TALK for mailing takes a part time employee, Richard Marmillion, twenty hours each week. One Health Improvement Association home adviser asked, for example, that every elementary and high school student in her county be placed in the mailing list. If this and similar requests were filled, HEALTH TALK could easily become a major full-time production, clerically and economically. One Chicago nun was retained in the mailing list when she was transferred to a South Dakota hospital. So many requests were received from South Dakota, it was considered expedient to remove the nun's name from the list, even though the Committee was aware of her appreciative interest.

Requests for being placed on the mailing list have come from California, Kansas, Canal Zone, Tennessee, Missouri, Oklahoma, Oregon, Virginia, New York, Pennsylvania, Michigan, Indiana, Minnesota, South Dakota, Ohio, Arkansas, New Jersey, Louisiana, South Carolina, Massachusetts, Wisconsin, Idaho. Each request is acknowledged with a regretful note that the mailing is restricted to Illinois. At the writing of this report, forty new names received in the two week period ended April 5 were yet to be added to the monthly list.

Compliments come to the Committee for the simplicity, sincerity and easy readability of HEALTH TALK, and the demand for it indicates its widespread popularity.

A Chicago physician, formerly a county medical society secretary, asked to be retained on the weekly mailing list. He said his folder of HEALTH TALK in his downtown office was read with greater interest than any other publication.

## MISCELLANEOUS

It would be difficult to gauge the time consumed in the actual writing of HEALTH TALK, giving telephone information and spent with visitors in the Chicago office. This report outlines only the result of production; not the time and effort to accomplish it. The Educational Committee is in direct contact with each of its activities. All members personally review every radio manuscript and every issue of HEALTH TALK. In the past year thirty-seven letters, averaging four pages in length, and telephone calls kept the Committee informed of activities in the Chicago office. In addition, numerous informal visits have been made to the office by individual members of the Committee.

The Secretary addressed the Princeton Woman's Club, March 22, attended the PR Institute of the American Medical Association, meetings of American Women in Radio and Television, the Chicago Publicity Club and Joint Committee on School Health Services. The Secretary also arranged a conference for Arthur Snider of the Chicago Daily News with Karl L. Vehe, Co-Chairman, Joseph T. O'Neill, member of the Educational Committee, and Walter C. Bornemeier, President of the Chicago Medical Society. The purpose was to discuss a series of proposed articles on the selection of a physician based on five issues of HEALTH TALK covering the subject.

The Committee personnel continues its services to the Scientific Service Committee and the Committee on Medical Economics. "News of the State" and obituaries, averaging at least five pages in every issue, are prepared for the Illinois Medical Journal. Several large mimeographing jobs have been performed for the Woman's Auxiliary to the Illinois State Medical Society for meetings in Champaign and Chicago.

Extensive services were rendered to Dr. Louis R. Limarzi in his capacity as Chairman of the Committee on Arrangements for the 1954 Annual Meeting and to Chairmen of individual committees. Letters of notification and complete lists of all committees were assembled and mimeographed and then mailed to chairmen and vice chairmen as well as to the individual members of the respective committees. In addition details incident to the arrangement of meetings of various committees were handled.

The Committee has worked together as a cohesive unit. It has aimed constructively for the fulfillment of the objective for which it was created in 1922—the dissemination of sincere and authentic health information. In submitting this report the Committee expresses its appreciation to the 198 physicians who so wholeheartedly cooperated in all its activities: Speakers' Bureau, radio and television. It pays particular tribute to its Secretary, Miss Ann Fox, for her constant and sincere service and to Mrs. Kay Simmons of the

Chicago office, not only for her efficiency, but her loyal cooperation.

The Educational Committee gratefully acknowledges the trust given to it by the Council during the past year and expresses its appreciation to the House of Delegates for a similar confidence.

Respectfully submitted, CHARLES P. BLAIR, M.D., *Chairman*. KARL L. VEHE, M.D., *Co-Chairman*. JOSEPH T. O'NEILL, M.D., GEORGE V. BYFIELD, M.D., GEORGE L. DRENNAN, M.D., HARLAN ENGLISH, M.D., MISS ANN FOX, *Secretary*.

DR. CHARLES P. BLAIR: As a supplementary report, the Educational Committee is happy to announce that on May 12 the Secretary, Miss Ann Fox, won another first place award in the Annual Contest of the Illinois Woman's Press Association. The prize winning material was the issue of HEALTH TALK "Our Youth Grows Up" which won first place in the classification "best column in a weekly paper."

This is particularly gratifying to the Committee, since HEALTH TALK is one of its major activities and represents the original writing of Miss Fox who also created this weekly story. This award is additionally gratifying because it is the seventh such award received by HEALTH TALK and the Secretary in the last four years, two of which were on a national level by the National Federation of Press Women.

The Educational Committee wishes to commend wholeheartedly the recommendation of Dr. Edwin Hamilton that the Illinois State Medical Society contribute \$1,000 to the Educational Television Station, Channel 11, which is now being developed in Chicago. The Committee has a deep awareness of the vast influence of television as a teaching medium and appreciates sincerely the wisdom and sagacity of Dr. Hamilton in suggesting that the Illinois State Medical Society be represented among the contributors to Channel 11, whose call letters will be WTTW.

Respectfully submitted, CHARLES P. BLAIR, M.D., *Chairman, Educational Committee*.

#### ETHICAL RELATIONS COMMITTEE

The Ethical Relations Committee of the Illinois State Medical Society met in July, 1953 to consider the appeal taken from the Sangamon County Medical Society by the Springfield Clinic. This was followed by a hearing in Springfield in August, 1953. The committee upheld the findings of the Sangamon County Society. This decision was appealed to the Judicial Council of the A.M.A. and the Chairman of the Committee together with Dr. Harold M. Camp and Dr. Lee Stone attended the appeal at the offices of the A.M.A.

An appeal to the State Medical Society was taken by Dr. Loumos from the decision of the Ethical Relations Committee and the Council of the Chicago Medical Society expelling Dr. Loumos from membership by reason of his associating himself as a front for a Nutritional Service Company in Chicago. It was

the opinion of the Ethical Relations Committee that the action by the Council of the Chicago Medical Society be sustained.

Respectfully submitted, ARTHUR C. TAYLOR, M.D., *Chairman*. CHARLES ALLISON, M.D., V. E. ADAMS, M.D., *Ethical Relations Committee*.

#### COMMITTEE ON INDUSTRIAL HEALTH

The Committee on Industrial Health of the Illinois State Medical Society has made a concerted effort to further the cause of occupational medicine in the State of Illinois through a vigorous and active program which had its inception in August, 1953. Although this relatively new and important field of medicine has made tremendous strides in the last twenty-five years, it was realized that generally physicians are still quite unfamiliar with many of its phases. Surveys have shown that approximately 95 per cent of physicians engage in the practice of industrial medicine to some extent since many of their patients are drawn from the ranks of the gainfully employed.

To develop an effective program your Committee at its first regular meeting outlined and adopted a comprehensive schedule of activities for the year which concluded such items as indoctrination of physicians in the more important fundamentals of industrial medical practice, differential diagnosis of occupational diseases such as silicosis and siderosis, application of modern techniques in industrial hygiene to provide safe working environments, and recognition of the implications of improper diagnosis of occupational disease on the employee, employer and insurance carrier.

To attain the foregoing objectives, specific assignments were given to each member of the Committee. These were as follows:

(1) Sending out brief informative articles at stated intervals either as special brochures or in the Illinois Medical Journal clearly marked "From your Committee on Industrial Health," and covering such topics as "Pitfalls in Occupational Disease Diagnosis" or "The General Practitioner's Approach to Industrial Medicine."

(2) Encouraging of closer contact between local physicians and manufacturing concerns.

(3) Improving medical relations with compensation commissions, attorneys, labor departments, public health and other agencies.

(4) Sending letters to management through such organizations as the Illinois Manufacturers Association as to what is being done to promote industrial health.

(5) Encouragement of meetings sponsored by industrial concerns to familiarize local doctors, safety engineers, hygienists, etc. with occupational health problems and how these may be solved.

(6) Cooperation with local medical societies and safety organizations and assistance in supplying speakers on industrial, medical and hygiene subjects.

(7) Contacting university medical schools to promote the teaching of occupational medicine at the undergraduate level.

(8) Publication of a series of five articles on industrial medical subjects by outstanding authors in the Illinois Medical Journal during the coming year. Two of these have already been submitted and accepted.

The Committee has held four regular meetings thus far at which real progress on all these assignments has been reported.

Of special interest has been the study of medical relations under Workmen's Compensation in Illinois, conducted by your Committee on Industrial Health. In accordance with a resolution adopted by the House of Delegates of the American Medical Association at its annual meeting in 1950, the Council on Industrial Health has been investigating the present status of medical relations under workmen's compensation laws of the states, territories, and the Federal government, reporting its findings to the House of Delegates.

In June, 1953 Illinois was selected as the location for a survey of an individual state. Information was collected in interviews with policies and actual practices in medical relations under workmen's carriers, the bar and the medical profession as well as past and present officials of appropriate state agencies. Additional factual material was obtained from official publications. At its annual meeting October 2-3, 1953, a report of the survey was approved by the Council on Industrial Health of the American Medical Association for its study and information and further collaborative action between the State Committee and the Council on Industrial Health.

The purpose of this report is to provide factual information for the medical profession and other interested persons on the background policies and actual practices in medical relations under workmen's compensation in Illinois. This report has been adopted by your Committee as the basis for further recommendations designed to correct abuses and elevate standards of medical care and administration under present Illinois Workmen's Compensation Act and the Illinois Workmen's Occupational Diseases Act.

Much credit for the Report on Medical Relations under Workmen's Compensation in Illinois is due Mrs. Marjorie Grigsby who conducted the personal interviews and assembled the factual information contained in the report.

The Council on Industrial Health of the American Medical Association unanimously agreed at its meeting in Louisville to permit Mrs. Grigsby to serve in an advisory capacity to the Committee on Industrial Health of the Illinois State Medical Society.

The preliminary draft has been submitted to the Council of the Illinois State Medical Society and also the Committee on Public Relations and publication of the revised report at the expense of the Illinois State Medical Society has been approved.

Great interest has been manifested in this venture by the medical and legal professions, bar associations, manufacturers associations, and insurance carriers in Illinois as well as in a number of other states. It

is apparent that there is ample support for revision of the compensation laws throughout the country and it seems desirable and logical that the medical profession of Illinois should lead the way in instigating these long overdue reforms. Your Committee intends to pursue this objective and plans for further definite action are well under way.

The Committee on Industrial Health has been directed by the Council to study and prepare specific recommendations for changes in the present acts to improve standards of medical care and administration; said recommendations to be submitted to the Illinois State Medical Society for implementation prior to the 1955 session of the Illinois State Legislature.

Your Committee has held personal interviews with the Deans of the University of Illinois College of Medicine, University of Chicago School of Medicine, Northwestern University Medical School, Stritch School of Medicine of Loyola University and the Chicago Medical School, to investigate the present status of medical education in the field of industrial medicine and to learn what plans if any are being considered for the teaching of a subject of such growing significance. While there appeared to be some general awareness of the idea, very little if any significant progress or interest was manifested.

At the University of Chicago, Doctor Herbolzheimer, who is Assistant Professor of Occupational Medicine, has been conducting classes in the field but the undertaking is more in the nature of public health and does not represent any direct connection with private industry.

As a result of the Committee's investigations it was felt that the University of Illinois would be a logical choice to institute refresher courses or discussionals for the physician who is already engaged in industrial work and the best opportunity to make a start in teaching occupational medicine in Illinois would be through this educational institution. The Committee on Industrial Health plans to give further consideration to this problem.

The Illinois State Medical Society was represented at the 14th Annual Congress on Industrial Health which was held in Louisville, Kentucky on February 23rd, 24th, and 25th, 1954 by Doctors Chivers and Hamlin. This was a highly successful meeting and, as in previous years, the joint conference of the committees on industrial health of the various state medical associations was an interesting and productive session.

The Committee has rendered additional services on several occasions to individual physicians and other medical societies. An outline of procedure in setting up an industrial medical program was furnished to an Illinois State Medical Society member who was planning to engage in this type of practice. At least two scientific exhibits on industrial medical topics were furnished for the North Carolina Medical Society's annual meeting through the efforts of the Committee. Information on how to get a committee on industrial

health to function actively was supplied to the Medical Administrator of the United Mine Workers of America.

Through the courtesy of Mr. A. D. Cloud, Publisher, copies of the Twenty-First Anniversary number of the Journal "Industrial Medicine and Surgery" were mailed to the members of the Council of the Illinois State Medical Society with the request that these be circulated as widely as possible throughout the association. This particular volume is devoted to the history and progress of occupational medicine and is a most interesting and educational issue.

Your Committee acknowledges with sincere gratitude the support of the Council and the House of Delegates. The interest and valuable assistance received from Dr. F. Lee Stone, Chairman, of the Council, who has attended all the meetings of the Committee have been deeply appreciated as has also the valuable help of Dr. Harold M. Camp, Secretary-Treasurer.

Respectfully submitted, LLOYD E. HAMLIN, M.D., *Chairman*, MILTON H. KRONENBERG, M.D., RICHARD J. BENNETT, M.D., JOSEPH H. CHIVERS, M.D., CARL M. PETERSON, M.D., CARL T. OLSON, M.D., *Committee on Industrial Health*.

#### MATERNAL WELFARE COMMITTEE

The Maternal Welfare Committee has held meetings for study of the reports on maternal deaths occurring in 1953, and which are assembled by a representative of the Illinois State Department of Public Health, Dr. Charles Newberger until shortly before his death, and Dr. Mary Otten, Springfield, since that time. The latter physician has been trained at the Research and Educational Hospital in the department of obstetrics and gynecology.

The committee will miss Dr. Newberger and it will be difficult to replace his keen appreciation of the importance of his work, the courteous manner in which he carried on his investigations, and his readiness to discuss impressions gained by the committee from a study of the reports with various county societies and hospital staffs.

The maternal mortality has continued its downward trend and has reached a low of .4 per thousand live births in the area outside of metropolitan Chicago, whereas, the rate within the metropolitan area was .3 per thousand live births.

The committee is preparing an exhibit for the State meeting showing on a map of Illinois the spots where maternal deaths have occurred, marked by a tiny cross of varying colors indicating the various causes of death. No towns or doctors names will be listed.

The committee has cooperated with the American Committee on Maternal Welfare in bringing together the various groups within the state which have a stake in maternal welfare such as the State University, other non-state universities, Loyola, Chicago University, Northwestern University Medical School, the Department of Public Welfare, the Illinois Obstetrical and Gynecological Society, the Chicago Gynecological So-

ciety, the Illinois Nursing Association. If these groups can be brought together working for a common cause the committee feels better maternal care will result throughout the state.

The committee also is cooperating with the American Committee on Maternal Welfare in sponsoring the Sixth American Congress on Obstetrics and Gynecology which will be held in Chicago December 13-17, at the Palmer House, under the joint auspices of the American Committee on Maternal Welfare and the American Academy of Obstetrics and Gynecology. This will be a five day session bringing together doctors, nurses, U. S. Public Health Officers, and Hospital Administrators who have a particular interest in the problems of maternal and newborn care.

Respectfully submitted, FRED H. FALLS, M. D., *Chairman*, A. B. OWEN, M. D., F. J. P. TWOHEY, M. D., W. R. YOUNG, M. D., R. R. LOAR, M. D., MILTON BITTER, M. D., J. B. WALLER, M. D., CARL GREENSTEIN, M. D., C. E. AHLM, M. D., W. C. SCRIVNER, M. D., J. C. CAREY, M. D., *Maternal Welfare Committee*.

#### COMMITTEE ON MEDICAL ECONOMICS

Your Medical Economics Committee has been actively engaged in fulfilling its function of offering a monthly article on this subject for publication in the Illinois Medical Journal. The members of this group have worked together in a fine fashion. Although we did not hold a formal meeting the members kept in contact with one another by letter, phone, and personal conversation.

The committee attempts to keep only a small backlog of articles. In this way we can stay abreast of the times and our articles will consider up to date problems and have some punch to them.

We are told that there would not be space available to us in the July 1953 number of the Journal. With that exception we have published an article in each issue.

Since our last meeting we have offered the following articles: "V. A. Hospitals and Socialized Medicine;" "The Future of Wisdom in America;" "Public Aid Medical Program, Part I;" "Voluntary Health Insurance on Trial;" "The Cost of Medical Latin;" "Wake Up," a critique on public relations; "Avoidable Hospitalization;" "Let's Sue Doc;" "Deadline Medicine," a plea for better press relations; "The House Staff Problem;" "Illinois Public Aid Program, Part II;" and "The Need for Revision of the Coroner's Act of the State of Illinois."

The above articles were written either by individual members of the committee or by guests invited for their special knowledge and interest in their subject. The papers were reviewed by the entire committee before publication. These reports are the babies of the entire group.

The committee is grateful to know that the medical economics section is becoming a popular one. Each author has received many "fan mail" letters, both pro and con to his discussion.

The committee would like to thank Miss Ann Fox and the workers in the Chicago office for their cooperation in aiding our program. Our editor, Dr. Harold Camp, has shown great interest in the work of the committee and this has done much to stimulate the development of our project.

Respectfully submitted, JOHN R. WOLFF, M. D., *Chairman*, WALTER C. BORNEMEIER, M. D., EDWARD W. CANNADY, M. D., ROLAND R. CROSS, M. D., E. F. DIETRICH, M. D., W. W. FULLERTON, M. D., EDWIN F. HIRSCH, M. D., FREDERIC T. JUNG, M. D., W. R. MALONEY, M. D., CAESAR PORTES, M. D., WILLIAM REQUARTH, M. D., FREDERICK SLOBE, M. D., *Committee on Medical Economics*.

#### COMMITTEE ON MEDICAL HISTORY

This Society has indulged in other ventures in the writing of a history of medical practice in Illinois. About 1890 it was suggested that a history be undertaken to be completed about ten years later. Apparently nothing was done about it. In the middle 90's the House of Delegates ordered Dr. W. O. Ensign of Rutland to write a history of the Society. It was to be presented at the next annual meeting of the House. That also apparently was not written. Dr. Ensign was ill at the time of the next annual meeting and there was no further mention of it.

In 1913, on orders of the Council, Dr. Carl E. Black brought out a general index of the Society's transactions. From 1850 until the Journal was founded in 1899 the annual transactions were put out in bound volumes. These contained the names of those who registered, the titles of papers and those who presented them, and the names of discussants. Curiously, some men who took part in the proceedings did not bother to register. Dr. Black said that one of the reasons for getting out this index was the hope that it would stimulate other men to write a more detailed history.

In 1927 Volume I of the "History of Medical Practice in Illinois" was brought out. Dr. Lucius Zeuch was editor. A great deal of data was accumulated by that committee. Unfortunately, all of it not incorporated in Volume I was lost.

Many other state societies are writing or have written histories, either of their society or of medical practice in their state. Our Society appears to have embarked on a policy of continuing to write a history of medicine. This is Volume II. In the process of collecting material for this, the Committee has accumulated a great deal for Volume III. All of it is preserved in the Crerar Library—which will save a great deal of time and labor on the part of the committee getting out the next volume.

The present Committee was to cover the period 1850-1900. There is some overlapping, however, of the material in Volume I, and, in some instances, we do not quite bring it up to 1900. These defects were apparently unavoidable.

The Committee had a choice of two methods of

preparing this volume. It could employ a historian, a nonmedical person, who would collect such data as he would consider significant and then incorporate it in a volume, subject to the Committee's approval. The other method, was to select various members of the Society who had special interests or perhaps special knowledge in various fields of medicine and ask them to prepare a chapter covering the segment in which they were particularly interested. This was the slower method. Men who were qualified to contribute were always busy. Writing a chapter for this book simply added another burden to their already busy lives. The fact that so many men have contributed is undoubtedly a tribute to the respect and affection in which our permanent historian is held.

Contributors have understood that, when all the chapters were assembled, it might be necessary to condense some of the material to make it fit a volume of the size planned. Each contributor, however, was to see his material before publication and to approve or change it as he saw fit. The complete manuscripts are on file in the Crerar Library.

Dr. D. J. Davis has consented to act as editor. Many of the chapters are ready for the publisher. It is hoped that this book will picture medical practice in Illinois in the period covered and also show the part played by the doctor as an individual and, also through his organizations, in the other activities of the state—political, educational, religious, business, welfare, etc.

The Committee has had the Council's cooperation. Dr. F. Lee Stone, its chairman, with Dr. Camp, Dr. Reichert, Dr. Oldfield and Dr. Blair are a publication Committee, which is looking into the cost of getting out this volume. It is not expected that this will become a best seller, but those chapters which the chairman has had the privilege of reading are so interesting that he ventures the opinion that men who once begin the volume are not likely to stop until they have finished reading it.

The Society will always be indebted to the men who have contributed various chapters and particularly to Dr. Davis.

This report should have been submitted to every member of the Committee. For a number of reasons that was not possible. However, any member of the Committee who wishes to change, add to, or subtract from this report has the privilege of appearing before the Reference Committee, and this report should in no way prejudice what he might have to say.

Respectfully submitted, JAMES H. HUTTON, M. D., *Chairman*. JOSIAH J. MOORE, M. D., DAVID J. DAVIS, M. D., E. H. WELD, M. D., GEORGE COLEMAN, M. D., JAMES P. SIMONDS, M. D., CHARLES P. BLAIR, M. D., TOM KIRKWOOD, M. D., WILLIAM A. MANN, M. D., FREDERICK W. MERRIFIELD, M. D., KELLOGG SPEED, M. D., ARCHIBALD HOYNE, M. D., B. BARKER BEESON, M. D., MISS ELLA SALMONSEN, *Secretary, Committee on Medical History*.

DR. JAMES H. HUTTON: I have a supplementary report.

I would like to tell you something more about Volume II of the History of Medical Practice in Illinois. In size it will be like Volume I. It will run to about 700 pages. The number of pictures it will contain is uncertain. The biographies will be few and short. It will contain a vast amount of interesting material — something about medical education, the practices and procedures of early medical men, the cost of medical care, and many other interesting features.

*Medical Education.*—Early medical schools had great difficulty in obtaining cadavers. A number of interesting things occurred along this line, and Dr. Kampmeier, who wrote the Chapter on Anatomy, has used some of them as a background for what happened in Illinois. The dissection of the human body was looked upon with horror. Princeton University to this date has no medical department because for a long time — and perhaps yet — there is or was on its statute books a law which prohibited the dissection of the human body. (George Lull)

A number of riots occurred in this country because of grave robbing practices. In the 1770's there occurred in New York what is known as the Doctors' Riot. Doctors were accused of — and undoubtedly were guilty of — robbing graves. This particular mob ran for several days. All the doctors were chased out of town or into jail, and the mob stormed the jail. Governor Clinton called on the militia. As he marched toward the jail Baron Von Steuben of Revolutionary fame accompanied him, saying "Don't fire, Governor, don't fire." At that moment one of the mob managed to land a brick on the Baron's head, and as he went down he shouted, "Fire, Governor, fire!" The Governor did and about half a dozen people were killed.

One of the first schools in Illinois, located at St. Charles, was closed because a mob stormed it, killed a student and permanently injured Dr. George W. Richards, the head of it.

When Rush Medical College opened, dissection was an elective course. Students were advised but not required to take it.

In Vermont two boys were sent to prison for robbing graves. One of them when he came out went ahead and completed his medical education and located at Lockport, Illinois. Later he got himself elected to our State Senate and probably was instrumental in having the law passed which legalized the procurement of cadavers for medical schools.

Dr. Kampmeier heard that an ex-mayor of Joliet knew something about this doctor. So he drove to Joliet and after considerable trouble located the ex-mayor, who told him all that he knew about the doctor and then said that a farmer out in the country had known the doctor personally. So Dr. Kampmeier and the ex-mayor drove out into the country to obtain this little bit of information. That trip must have occupied the major portion of an entire day. That shows the great amount of time and effort that has gone into collecting the material for this history.

Doctors of the period covered by this history for the most part had only their five senses to work with. Dr. Tom Kirkwood has written a Chapter on General Practice which brings out those facts. He tells of a girl who claimed to have swallowed poison. The doctor was called. He looked her over with considerable skepticism. Then, disregarding her, he turned to the mother and began to mix a potion, remarking that he felt terribly sorry for this girl, that if she had actually swallowed the stuff as she claimed to have done, the medicine would surely cure her, but if she was mistaken, God help her, it probably would kill her.

Another tells of a girl who had spells of weakness and what-have-you. She took to bed and nothing could get her up. Her mother worried and did all the work. Her father was unhappy. The neighbors took an interest. As a matter of fact, she became the center of neighborhood gossip and she gloried in the fact, probably, that she did not respond to the doctor's medicine. A new doctor came to town. Word got around that on a certain day he would come in to see her. As he drove up he noticed teams tied on both sides of the road. He realized that the neighbors had decided to watch his performance — and probably defeat. He went in and looked her over. No blood count, no urinalysis, no blood chemistry, no spinal puncture — no laboratory work. The examination, of course, disclosed nothing of any significance. So he slowly took off his coat and hung it on the back of a chair. Then he took off his vest and hung it over his coat. Then he slid one suspender off his shoulder and sat down on the side of the bed. By that time the girl's defiance had changed to apprehension. As he took off a boot and dropped it on the bare floor, the apprehension increased; and as he slid off the other suspender, she said, "Doctor, what do you all mean to do" He said, "If you can't get out of bed, I am going to get right in there with you as quickly as I can take off my pants." She gathered the sheet around her and broke the record for the 50-yard dash. If she had a submerged complex, he certainly disinterred it. A psychoanalyst could have done no better.

Dr. Fred Falls, in his Chapter on Obstetrics, points out that when DeLee graduated he had seen only two cases delivered. Both were in the anatomical amphitheater. They wheeled out the cadavers and wheeled in the pregnant ladies. DeLee watched the procedure through opera glasses from the top row of seats of the amphitheater. He was little better off than the girl in Bourbon County, Kentucky.

But don't get the idea that these men were not on their toes. Dr. Will of Peoria was doing what was the equivalent of a Papanicolaou smear, before Papanicolaou was born. He had a microscope and that was something in those days. He examined the lochia, thought he saw a sarcoma cell, went back and got a biopsy and followed the lady to post to prove that he was right.

They were a rugged lot. Picard and Bulley wrote a

book, "The Midwest Pioneer — His Ills, Cures and Doctors." They dedicated it to "the pioneer doctor who boldly faced the wilderness and the pioneer who bravely faced the doctor."

Bleeding was quite the thing until the latter part of this era. They tell of an enterprising fellow in Indianapolis who had a trough constructed that led from his treatment room to the outside. The patient laid his arm in the trough, the doctor opened a vein, the blood flowed outside, and when the patient fell off his perch he had had enough bleeding.

We hear discussion of the high cost of medical care. That is so much nonsense — a failure to appreciate what is going on. In those days fat steers sold for \$7.50 per head and quinine for \$6 to \$8 an ounce. That would be enough for a malarial patient for one week. What goes on now? A synthetic drug can be purchased for a dollar or less, and a few doses will practically cure the disease. And a fat steer sells for \$500 or so.

Typhoid has practically disappeared, also malaria, smallpox, scarlet fever and diphtheria. During this era Dr. Waxham achieved considerable reputation for his skill in intubation. One night he made three round trips by horse and buggy from Grand Boulevard to Western Avenue to replace a tube coughed up by a child with diphtheria. That is a trip of twenty odd miles. Prior to 1900 all the money that all the governments in all the world had couldn't buy a single unit of penicillin, a grain of sulfa or a gram of cortisone. The average length of life has increased from 40 to about 67 years, and that is something that could hardly be bought at any price.

Medical literature was almost non-existent in the early part of the previous century, and it was very scant during the era covered by this volume. But a number of medical men became interested in libraries. Dr. Kampmeier has devoted a chapter to that subject. It is extremely interesting.

Morgan County had one of the early libraries, and at its annual meeting in 1895 this Society congratulated Morgan County on its library. Winnebago County also had quite a library. Dr. Crawford did a lot of traveling, surveying the field for it. Danville also has a very good one. Dr. Kampmeier traced all over the state looking into this matter. It was about 1885 that this Society adopted a resolution and appointed a committee to look into the wisdom, propriety and best method of aiding public medical libraries. Unfortunately, nothing came of it.

Dr. James S. Jewell left quite a library to what is now the University of Illinois. When he was a student, it was recorded that he was an awkward, ungainly, shabbily dressed youth and that the students in his class made considerable fun of him.

None of you will find this history dull reading. It is hoped that every member of this House will order a volume. One of the first orders came from a doctor in Manchester, New Hampshire. There is downstairs in the exhibit hall, some exhibits on Medical History.

DR. G. HENRY MUNDT, Chicago: When the first volume was published we paid for the whole thing. A woman in Houston, Texas who was interested in the early history of the American Medical Association ordered the two volumes. Every year about January 1st I receive a note from her asking when the next volume is to be published as she paid for it.

THE PRESIDENT: This supplementary report by Dr. Hutton will be referred to Committee "D".

THE SECRETARY: When the first volume was published in 1927 there was quite a little material accumulated for that purpose and within a very short time to present it as a supplement. Dr. Whalen developed the idea that that small supplement would be sent gratuitously to all subscribers to the original volume. That has been twenty-seven years ago and that supplementary volume was never prepared.

#### COMMITTEE ON MENTAL HEALTH

Your committee has made some attempt this year to invite the attention of physicians in general practice, as well as specialists, to phases of the mental health problem. Last summer after approval by the Council, through the help of the Illinois Mental Health Authority of which the chairman was a member and with the cooperation of the Illinois Society for Mental Health, a copy of the Psychiatric Bulletin was sent to each member of our society. This publication is a nontechnical one which brings out, nevertheless, applicable phases of mental health applied to general medicine. The Monmouth office supplied the mailing list for this distribution. No direct request for subscriptions was made but opportunity for such was presented. Mr. Louis de Boer, Mental Health Education Consultant for the Illinois Department of Public Welfare, reported a fair response and raised the question of repetition of this effort this year. We would recommend it.

As a follow-up of that and with the recognition that the private practitioner is in the front line in recognition, attempts at prevention, and in treatment of major and minor mental illnesses your committee has asked each component and branch society to appoint its own Committee on Mental Health if such did not already be in effect. Favorable response has been received from many societies. We urge the delegates to carry home to their respective societies recommendations for such appointments.

As a closer tie-in of organized medicine in Illinois with both public and private agencies a meeting of the committee with Dr. Otto Bettag, Director of the Department, and Mr. de Boer is planned for the time of the Annual Meeting. Members of the committee have been interested in the medical service and other features of the State Hospitals.

The chairman talked before a meeting of the Illinois Psychiatric Society in Chicago in January and before local groups on other occasions. It is felt that the more widely interest can be stimulated the better the

results will be for our patients and ourselves. We are pleased with the program planning for the Annual Meeting wherein various neuropsychiatric conditions are discussed.

A recent listing by the Illinois Department of Public Welfare shows that there are eight general hospitals in the Chicago area and two downstate with approved psychiatric units. There are twenty recognized private sanatoriums or hospitals in the metropolitan zone and six downstate. Twelve State Hospitals and three Veterans Administration Hospitals complete the "Register of Public and Non-Public Hospitals in Illinois Authorized or Recognized for the Treatment of Mental Disorder."

Outpatient and clinic facilities on an organized basis are tied in with the general and public hospitals and on an office or consultation basis with the private ones. However, the problem of care and treatment of many individuals in many communities either with or without psychiatric facilities is much broader than that and lies within the province primarily of the membership of the Illinois State Medical Society.

Respectfully submitted, F. GARM NORBURY, M. D., *Chairman*, OSCAR O. HAWKINSON, M. D., ABRAHAM LEVINSON, M. D., WALTER H. BAER, M. D., C. C. ELLIS, M. D., *Committee on Mental Health*.

#### COMMITTEE ON MILITARY AFFAIRS AND EMERGENCY MEDICAL SERVICE

Since the approval of the State-wide Plan for the Utilization of First-Aid Stations and Improvised Hospitals in Civil Defense (see Handbook report of this Committee) this committee has been on a stand-by basis, awaiting the procurement of supplies and equipment needed and the establishing of organized units in the communities served.

The Deputy Director for Health, Illinois Civil Defense Agency, advises the Committee that to date no purchase of First-Aid or Improvised Hospital equipment has been made, on a Community basis, to implement a Civil Defense Health Service for the State of Illinois. The utilization of first-aid stations and improvised hospitals is under consideration by a number of communities. The City of Chicago has taken no steps during the past year to implement a Civil Defense Health planning, and a deterrent to downstate action.

The advent of the hydrogen bomb with its greater area of destruction brings the realization that about 65 per cent of the hospital beds in the city of Chicago, with a similar per cent of Health Service personnel, would be rendered inoperative following such an attack.

This would render Chicago incapable of furnishing adequate Health Service to its population without help coming from the mutual aid Civil Defense units and would necessitate the utilization of all aid stations and improvised hospitals in the present over-all State Plan.

It would seem that the major effort must come from communities outside the City of Chicago. We believe the inherent inequalities in this situation basically unfair and that the State, through legislative appropriation

should render financial assistance on an equitable basis under the Federal matching program. We therefore suggest a Resolution to the Governor of the State making such recommendations.

Respectfully submitted, EARL H. BLAIR, M. D., *Chairman*, F. T. BRENNER, JR., M. D., PLINY R. BLODGETT, M. D., KENNETH H. SCHNEPP, M. D., ROLAND R. CROSS, M. D., LEO P. A. SWEENEY, M. D., PHILIP LEWIN, M. D., GILBERT EDWARD, M. D., *Committee on Military Affairs and Emergency Medical Service*.

#### COMMITTEE ON NECROLOGY

Once again it becomes the sad duty of your Committee on Necrology to report the death of many of our members of the Illinois State Medical Society. Some of these physicians have become famous from scientific attainments, some as teachers of medicine, some as writers, or some in other professional activities. Some have held office in the Illinois State Medical Society or in their county medical societies.

There are a few who deserve special mention: Frank Deneen, Newell C. Gilbert, Mark T. Goldstine, James B. Herrick, Lawrence J. Hughes, Roswell T. Pettit, Arthur R. Rikli, Brown Pusey, John W. Nuzum, William E. Shallenberger, Willard O. Thompson, Frederick Tice, Clarence L. Wheaton, Darwin Pond, Homer J. Elkins, Rollin T. Woodyatt, Oliver S. Ormsby.

Now may we list, alphabetically, those members of the Illinois State Medical Society who passed away during the past fiscal year.

Arensdorf, Edward L., Chicago, died December 5, 1953.

Bailey, Alfred S., Chicago, died August 27, 1953.

Ball, Otho F., Chicago, died June 19, 1953.

Baxter, Lewis T., Elmwood Park, died November 12, 1953.

Blum, Victor G., Chicago, died March 3, 1954.

Bogardus, Charles S., Clinton, died February 2, 1954.

Boynton, Lloyd V., Peoria, died July 12, 1953.

Brown, J. Archibald, Kankakee, died November, 1953.

Burgner, Benjamin H., Chicago, died October 15, 1953.

Cartmell, Harry D., Greenville, died September 2, 1953.

Chaloupka, Arthur J., Chicago, died September 3, 1953.

Clagett, A. N., Evanston, died September 20, 1953.

Clowes, Leo C., Hinsdale, died June 9, 1953.

Cohen, Benjamin, Chicago, died January 30, 1954.

Colehour, Samuel P., Mt. Carroll, died August 10, 1953.

Collins, Loren L., Edwardsville, died May 1, 1953.

Cook, Frances H., Chicago, died September 29, 1953.

Crooks, T. T., Chicago, died May 9, 1953.

Delph, John F., Chicago, died November 7, 1953.

Deneen, Frank, Bloomington, died April 13, 1954, following a heart attack, at the age of 63. Doctor Deneen was a regular attendant at the annual meetings of this society, and had been a delegate from his local component society. He was formerly an officer in the Section on Medicine, and he was the author of a number of scientific articles, which ap-

- peared in the Illinois Medical Journal and other publications.
- Deutsch, I. Herman, Oswego, died August 27, 1953.
- Dixon, W. S., Metropolis, died May 23, 1953.
- Dohrmann, George, Chicago, died September 25, 1953.
- Donahue, James J., East St. Louis, died August 10, 1953.
- Dyke, William E., Chicago, died September 26, 1953.
- Elkins, Homer J., Mounds, died February 18, 1954, at the age of 66. Dr. Elkins was prominent in the affairs of his county society, was frequently a member of the House of Delegates at annual meetings of this society, and was formerly secretary of the Pulaski County Medical Society.
- Fetherston, Ernest, Winnetka, died January 5, 1954.
- Fisher, G. Carl, Chicago, died February, 1954.
- Fordyce, Alexander W., Gilman, died February, 1954.
- Fox, Charles M., Chicago, died September 23, 1953.
- Frazier, Harold L., Chicago, died October 3, 1953.
- Freedman, I. Val, Phoenix, Arizona, died August 3, 1953.
- Froehlich, Kurt P., Moline, died March 25, 1954.
- Frymire, William A., Monmouth, died April 16, 1954.
- Gerety, William F., Danville, died 1953.
- Gilbert, N. C., Chicago, died August 1, 1953. He had been clinical professor of medicine, then a full professor at Northwestern University Medical School. He was senior attending physician at St. Luke's Hospital for a number of years, and was prominent among the cardiologists of this area. Doctor Gilbert frequently appeared on postgraduate programs in various parts of the state, and was prominent in the many societies of which he was a member.
- Golden, I. J. K., Chicago, died May 19, 1953.
- Goldstine, Mark T., Chicago, died March 4, 1954, at the age of 75. His particular interest was in obstetrics and gynecology, and he became an instructor in that department at Northwestern University Medical School in 1911, and became a full professor in 1943. He was chairman of the Department of Obstetrics and Gynecology at Wesley Memorial Hospital.
- Goodrich, William Ray, Bluford, died July 15, 1953.
- Graham, Fred W., Morris, died July 13, 1953.
- Hardt, Harry G., Chicago, died June 5, 1953.
- Harrison, Edwin M., Chicago, died June 24, 1953.
- Harvey, James A., Chicago, died June 11, 1953.
- Hash, Evaline St. Croix, Chicago, died February 11, 1954.
- Hathaway, Robert M., Hamilton, died April 1, 1953.
- Henderson, Ira M., Chicago, died February 26, 1953.
- Herrick, James B., Chicago, died March 7, 1954, at the age of 92. Doctor Herrick was the first to describe and diagnose coronary thrombosis in 1912, and that same year reported his findings in the Journal of the American Medical Association. In 1918 he had the first electrocardiograph in Illinois, and became able to confirm the diagnosis of coronary diseases, and estimate the damage to the heart muscle. He was one of the founders of The American Heart Association, American College of Physicians, and was a member of many scientific organizations. In 1939 he received the A. M. A. distinguished Service Medal for his outstanding work on coronary disease. He was professor of medicine at Rush for many years, and was president of the staff of Presbyterian Hospital. Thousands of physicians in Illinois and throughout the nation had Doctor Herrick as a teacher, and prize this association highly.
- Hiett, Alva, Monmouth, died December 9, 1953.
- Hiller, Frederick, Chicago, died June 28, 1953.
- Hoffman, Burton L., Chicago, died December 2, 1953.
- Horwitz, Sandor, Peoria, died January 17, 1954.
- Houston, Grant, Joliet, died September, 1953.
- Hughes, Lawrence J., Elgin, died May 21, 1953, after a long illness, at the age of 73. For several years Doctor Hughes was Councilor of the First Councilor District, giving up this position on account of his health. He was a member of the Fifty Year Club, and for many years was active in the affairs of this Society, as well as his component Kane County Medical Society.
- Hull, Richard B., Springfield, died May 19, 1953.
- Hussey, Raymond, Chicago, died April 15, 1953.
- Ivec, Martin J., Joliet, died September 28, 1953.
- Jackson, Bruce E., Chicago, died October 21, 1953.
- Jennings, John B., Peoria, died May 22, 1953.
- Klein, John, Chicago, died September 14, 1953.
- Koons, Charles, Creal Springs, August 9, 1953.
- Lebowitz, Joseph J., Chicago, died May 13, 1953.
- Legat, Mary B., Chicago, died October 28, 1953.
- Lesemann, Frederick J., Tucson, Arizona, died November 1, 1953.
- Lewis, Edward J., Chicago, died November 25, 1953.
- Lewis, John F., LaSalle, died October 9, 1953.
- Lieberthal, David, Chicago, died June 10, 1953.
- Link, Joseph J., Mattoon, died 1953.
- Lofgren, Emil, Rockford, died March 9, 1954.
- Lyon, Paul T., Chicago, died May 6, 1953.
- McClanahan, Benjamin V., Galesburg, died November, 1953.
- McCormack, Jas. L., Newton, died June 6, 1953.
- McGrail, William C., Chicago, died August 10, 1953.
- Mahoney, G. W., Wilmette, died June 11, 1953.
- Marquis, Benjamin V., Buffalo Prairie, died February 13, 1954.
- Masilko, Vandy F., River Forest, died August 21, 1953.
- Maurer, Franklin, Springfield, died May 24, 1953.
- Meany, Thomas E., Chicago, died March 21, 1953.
- Michael, Oscar W., Muncie, died November 3, 1953.
- Miller, Allen J., Chicago, died February 23, 1953.
- Miller, George E., Chicago, died March 2, 1953.
- Murrell, Charles M., Sherrard, died September 28, 1953.
- Newberger, Charles, Chicago, died September, 1953.
- Nichols, Harry, Chicago, died August, 1953.
- Nuzum, John W., Wilmette, died June 14, 1953, at the age of 54. He was long a member of the staff of Augustana Hospital, and was formerly an assistant of the late A. J. Ochsner. He was associate professor of surgery at the University of Illinois College of Medicine, and was the author of many surgical papers.

- O'Connell, John P., Chicago, died October 20, 1953.
- Perry, Eugene B., Chicago, died May 11, 1953.
- Pettit, Roswell T., Ottawa, died June 27, 1953, at the age of 68. Dr. Pettit, as an outstanding Illinois radiologist, was one of those responsible for the development of the Section on Radiology. He was a member of several state society committees, and was long active in the affairs of this society.
- Pond, Darwin, Chicago, died February 9, 1954, at the age of 74. Doctor Pond graduated from the Chicago College of Medicine and Surgery in 1907, and practiced for more than 45 years in Chicago. He was a member of the Council of the Illinois State Medical Society for one term, then resigned on account of his health. He was a member of the staff of Ravenswood Hospital, as an orthopedic surgeon. Besides memberships in the Chicago and Illinois State Medical Societies, and the American Medical Association, he was a Fellow of the American College of Surgeons. Doctor Pond was a regular attendant at the annual meetings of this Society for many years, and participated freely in the deliberations as a member of the Council and on numerous occasions as a member of the House of Delegates.
- Purvey, John C., Crystal Lake, died July 14, 1953.
- Pusey, Brown, Chicago, died July 4, 1953. For many years he was prominent in the field of ophthalmology in Chicago. He was a brother of William Allen Pusey, and a native of Kentucky. Dr. Pusey was head of the department of ophthalmology at Northwestern University Medical School from 1908 until 1927, when he received the designation of Professor Emeritus.
- Ridler, Hilda L., Rock Island, died February 12, 1954.
- Rikli, Arthur R., Naperville, died February 2, 1954, at the age of 77. For 35 years he was secretary of the DuPage County Medical Society and was a regular attendant at the annual meetings of this Society. At the time of his death, he was chairman of the Secretaries' Conference, with which group he was associated for a long period of time.
- Rubinfeld, S. H., Abingdon, died February 4, 1954.
- Schmidt, Florian E., Oak Park, died September 10, 1953.
- Schneck, Sereno W., Mt. Carmel, died April 21, 1953.
- Shallenberger, William E., Canton, died in 1953, at the age of 91. For a number of years he was secretary of the Fulton County Medical Society and a member of the House of Delegates from that county. He became a member of the Fifty Year Club in 1946, and he was greatly interested in medical history. He submitted data for the first volume of the History of Medicine in Illinois published in 1927, and since the publication of that volume, submitted additional historical data which is now in the archives of this Society at the John Crerar Library.
- Shearl, James M., Williamsville, died January 31, 1954.
- Snell, Noble R., River Forest, died October 22, 1953.
- Sodaro, Anthony, Chicago, died September 24, 1953.
- Stephens, Charles N., Industry, died 1953.
- Strauss, Fletcher L., Chicago, died October 20, 1953.
- Taphorn, D. Henry, Effingham, died 1953.
- Tatge, Edward G., Evanston, died September, 1953.
- Thomas, Elmer M., Aurora, died March 23, 1954.
- Thompson, Willard O., Chicago, died March 23, 1954, at the age of 55. A native of Canada, Doctor Thompson graduated from Harvard Medical School in 1923, and came to Chicago in 1929. He was associated with Rush Medical College for several years, and at the time of his death, was Clinical Professor of Medicine at the University of Illinois College of Medicine. He was a regular attendant at the annual meetings of this Society, a member of the House of Delegates, and on several occasions was chairman of an important reference committee. He appeared on postgraduate conference programs, and also appeared before many Illinois county societies to present a scientific paper.
- Tenczer, John F., Chicago, died 1953.
- Thomas, Harry V., Chillicothe, died September 19, 1953.
- Thompson, Lillian M., Chicago, died 1953.
- Thornton, Francis E., Chicago, died May 14, 1953.
- Tice, Frederick, Oak Park, died December 18, 1953, at the age of 82. Doctor Tice long associated with the Department of Medicine at the University of Illinois College of Medicine, was head of that Department for a number of years. He was the author of many text books, and wrote many scientific articles published in various medical journals. For several years he was president of the staff of Cook County Hospital, and was a former president of the Municipal Tuberculosis Sanitarium, and was very active in the fight against tuberculosis. Doctor Tice was a frequent attendant at the meetings of this Society.
- Toomajan, Harry J., Grayslake, died November 11, 1953.
- Vonnahme, Conrad B., East St. Louis, died June 8, 1953.
- Wheaton, Clarence L., Chicago, died during the past fiscal year, aged 80. He was active in the field of tuberculosis for many years, was formerly an instructor in medicine at Rush, and was seen frequently at our annual meetings. Dr. Wheaton conducted many tuberculosis diagnostic clinics in various parts of the state, and appeared before county societies to talk on this, his favorite subject.
- Wilson, William, Chicago, died October 3, 1953.
- Woodyatt, Rollin T., Chicago, died December 17, 1953. He was clinical professor of medicine at the University of Illinois (Rush Division). His interest in diabetes began before the discovery of insulin, and he did much research over the years on this subject. He was for many years a member of the staff at the Presbyterian Hospital.
- Worthington, Ernest J., Chicago, died May 23, 1953.
- Wright, Charles E., Rockford, died February 25, 1954.
- Wunderlich, Edwin B., Chicago, died July 5, 1953.
- York, Charles E., Chicago, died 1953.
- Zabokrtsky, Joseph, Oak Park, died July 12, 1953.

Zimmerman, Henry S., Cameron, died November 7, 1953.

May the life work of these physicians be remembered and revered by the many people they have served faithfully and well during their lifetime, and may they be remembered kindly for the good which they have done for mankind.

Respectfully submitted, ROBERT H. HAYES, M. D., *Chairman*, E. H. WELD, M. D., OSCAR HAWKINSON, M. D., *Committee on Necrology*.

COMMITTEE ON NURSING

Your Committee is aware of the confusion that exists in the minds of the general public regarding the nursing situation. It is possible to train for one year, one and one-half years, two years, three years, four years and five years, to graduate, and to receive the title of nurse.

The L. P. N. (Licensed Practical Nurse), in Illinois is an individual who has completed a one year course of study, usually in the Public School system, and has passed the Practical Nurse Board.

The R. N. is an individual who has completed three years or more of study and one who has passed the Professional Nurses State Board. It includes the group that has completed four or more years of collegiate study. The collegiate trained nurses will probably become teachers of nursing and will do little, if any, bedside nursing.

Our committee feels very strongly that the L. P. N. fills a very definite need, but should not replace the R. N. in bedside nursing. The R. N. who has graduated from a three years course in a Hospital School of Nursing, is the backbone of nursing care, and is extremely valuable in the rural areas.

ILLINOIS NURSING AIDE PROJECT

The Illinois League for Nursing has proposed that an extensive Nursing Aide Project be started in Illinois, which is sponsored by the National League for Nursing, American Hospital Association and the Public Health Service. The rapid growth in the use of auxiliary nursing personnel has indicated the need for assistance in developing practical ways to train auxiliary nursing personnel. The three National Organizations expect to set up an extensive program of regional workshops where nurses can develop teaching skills, and where they can obtain active assistance in setting up training programs in their organizations. The functions of the State committee, are the selection of teacher trainers, the planning for local workshops in Illinois, the interpretation of the program to Hospitals and Public Health Agencies, and consideration of financing the teacher trainer's salary and travel expenses. The workshop for the teacher trainers lasts five days; trainees are paid twenty dollars a day, and two dollars and fifty cents an hour for two one-half day follow-up visits to the Hospitals.

PRACTICAL NURSE TRAINING PROGRAMS

Forty-eight week courses are being conducted in four down-state centers and three Chicago schools. In Chi-

cago, five units are operating; two at Manley School, two at Princeton School and one at Greeley School. The downstate schools are located at LaSalle, Alton, Decatur, and East St. Louis. All training programs are administered through the Public Schools, except the LaSalle program, which is being operated by St. Mary's Hospital. Promotional work is being done in Rockford, Waukegan, Moline, Rock Island, Peoria and Quincy.

Current enrollment in Chicago Public Schools Practical Nursing Program is 311.

Manley Vocational School .....	48
Princeton School .....	47
Greeley Vocational School .....	16
Assigned to hospitals, etc. ....	200

Total .....	311
Number of graduates to date .....	656
Capacity for student admissions annually with present facilities .....	450
Employment surveys of all graduates:	
49% working in hospitals	
8% doing private duty	
13% in Public Health	
5% in Nursing Homes	
8% in Doctor's offices	
3% in non-nursing work	
1% in other types of Nursing	
14% unemployed	

PROFESSIONAL NURSES

In 1953 there were 80 State Approved Schools of Nursing. In 1954 there are 78, a loss of two schools. The enrollment is: 342 for college degree, 6,560 in hospital schools of nursing, and the total of 6,902 for the year 1953. In 1952, in Illinois, 2,850 student nurses were admitted, while in 1953, the admissions were 2,809.

Nationally accredited Schools of Nursing in Illinois:

Full accreditation:	
College Degree .....	1
Hospital Schools .....	16
Temporary Accredited:	
College Degree .....	1
Hospital Schools .....	44
Total .....	62

LICENSURE

There are approximately 49,000 professional nurses currently registered in the State of Illinois. There are about 5,823 licensed practical nurses in Illinois.

NATIONAL ACCREDITATION

The House of Delegates of the American Hospital Association in September, 1953, voted to approve the National League of Nursing's Program, rather than set up its own accrediting program for Hospital Schools. An executive committee on accreditation policies has been authorized by the National League for Nursing's Board of Directors to replace the former executive Board of Review for the accrediting service.

The new Executive Committee is made up of the following members:

Nursing, including one from A. N. A. ...6 members

Hospital .....5 members  
 3 from A. H. A.  
 1 from Catholic Hospital Assn.  
 1 from Protestant Hospital Assn.  
 American Medical Association .....1 member  
 Regional accrediting agency in general  
 education .....1 member  
 Higher education .....2 members  
 American Public Health Assn. ....1 member  
 Public .....1 member  
 The functions of this Committee:

1. Receiving reports from Boards of Review.  
 (Decisions as to whether or not nursing programs should be accredited, are made by Boards of Review.)
2. Considering problems and recommendations formulated by Boards of Review and formulating general procedures and policies.
3. Evaluating in relation to objectives, the program and policies of the Accrediting Service of the National League for Nursing.

### SUMMARY

In conclusion, your Committee on Nursing, is acutely aware of the shortage of nurses and the current trends in nursing. We strongly urge that everything possible be done to keep all of our present Hospital Schools of Nursing, and that we exhaust every means to obtain more Hospital Schools of Nursing, and to increase the enrollment in these Schools.

That we encourage the enrollment in Schools of Practical Nursing, and aid in the establishment of additional schools, but these schools should not be established at the expense of Hospital Schools of Nursing.

Respectfully submitted, M. M. HOELTGEN, M. D., *Chairman*. FRED H. MULLER, M. D., JOHN L. REICHERT, M. D., P. P. YOUNGBERG, M. D., *Committee on Nursing*.

### COMMITTEE ON NUTRITION

The 1953-54 Committee on Nutrition of the Illinois State Medical Society held its first meeting after appointment on July 2, 1953. This meeting was held at the Conrad Hilton Hotel, Chicago, in conjunction with the Twelfth Annual Institute of Conservation, Nutrition and Health of the Friends of the Land. Attending this meeting were committee members Warner H. Newcomb, G. C. Otrich and Paul A. Dailey; Lee Stone, Chairman of the Council of the Illinois State Medical Society. Representing the American Medical Association was Dr. James R. Wilson, Secretary, Council on Foods and Nutrition. Other guests present were Ollie E. Fink, Secretary, Friends of the Land; Robert L. Pendleton, Professor of Tropical Soils and Agriculture, Bowman School of Geography, Johns Hopkins University; Jonathan Forman, President, Friends of the Land; Louis Bromfield, Author and Farmer, Vice President, Friends of the Land.

The principal topic discussed at this meeting was the part that organized medicine should play in relation to nutrition. It was the concensus of opinion that human nutrition should be the primary concern of the physi-

cian and that soil nutrition and animal husbandry should be left to the Agronomists and those in the allied endeavors.

With the increased realization of the importance of good nutrition to health it was decided that renewed effort should be made to inculcate the coming medical men with a proper regard for food and diet. In line with this program the Committee on Nutrition, has secured Dr. William J. Darby, Vanderbilt University School of Medicine, Nashville, Tennessee, to speak on "What Lies Ahead In The Field Of Nutrition" at the General Assembly, Tuesday, May 18, Annual Meeting of the Illinois State Medical Society.

It is my opinion that a closer association of this committee with medical nutritionists is to be desired in the future. If possible I plan to attend Illinois Nutrition Committee Spring Meeting on April 20 at Champaign, Illinois.

Respectfully submitted, PAUL A. DAILEY, M. D., *Chairman*. LEE T. HOYT, M. D., G. C. OTRICH, M. D., WARNER H. NEWCOMB, M. D., JOHN P. O'NEIL, M. D., *Committee on Nutrition*.

### COMMITTEE ON PHYSICAL MEDICINE AND REHABILITATION

An effort was made to secure appointment of a qualified physician to the state board of examiners for physical therapists.

A letter was written to Judge Vera Binks, Director of the Department of Registration and Education, recommending several candidates for the appointment.

Respectfully submitted, EMIL D. W. HAUSER, M. D., *Chairman*, H. WORLEY KENDALL, M. D., DISRAELI W. KOBAK, M. D., STERLING PARKER, M. D., RICHARD J. BENNETT, JR., M. D., *Committee on Physical Medicine and Rehabilitation*.

### COMMITTEE ON POSTGRADUATE EDUCATION

The Committee on Postgraduate Education has arranged a total of twenty postgraduate presentations during the 1953-4 fiscal year. Harold M. Camp, M. D., Secretary of the Society, who attended all but one of the major meetings, estimates that more than 2,500 of our members have attended the postgraduate meetings. One hundred five teachers, all from Chicago, have contributed their time and energy to make these programs a success. We believe that this is the largest and most elaborate program the society has ever presented.

The accompanying chart presents the record in a form readily grasped. The meetings break down into three groups:

- a) Thirteen major meetings, each presented by three to ten teachers from the faculties of the five medical schools or the staffs of major teaching hospitals in Chicago.
- b) Six smaller meetings, each presenting three men, chosen usually without regard to teaching affiliations.
- c) Circuit-rider type meetings, in which one man goes to a hospital in a smaller downstate community, and works over the actual patient or group of patients with the physicians of the community. Only one

of these sessions has so far been held, but others are in the process of arrangement. The one held was enthusiastically received, and the committee desires to express its appreciation to Edwin F. Neckerman of Elmhurst, who has devoted much time and effort to these meetings.

It should be added that the meeting at Sycamore was postponed because of a surprise snowstorm, but was re-scheduled by the local society.

All the major and minor meetings followed the established pattern by including a social hour and dinner. Some also included luncheon. At each the Councilor for the district was added to the scientific program for a usually brief talk on medical organization. Thus it is believed that the meetings acted not only as a source of scientific and professional stimulus, but also as a social and organizational function.

As the scientific programs themselves, the panel method of presentation—with two or three speakers on various phases of a single subject followed by questions and discussion—has continued popular, and most of the programs have been in that form.

There is a great deal of office detail connected with and in the background of each of these successful meetings and we take this opportunity to express our great appreciation for their help to Dr. Camp at Monmouth and Mr. James C. Leary, director of public relations, at Chicago, for the efficient way in which this large mass of detail has been handled in their offices.

Perhaps a brief explanation of how these programs are handled will help in the organization of future programs. The dates and places of programs are set by the Councilors and then submitted to Dr. Camp

for approval. Once they are fixed, the chairman contacts some one at a school or hospital and asks him to select good speakers.

Subjects suggested by the local medical society are given preference, of course, but, if no suggestions are forthcoming, they are selected by the chairman.

Meanwhile Mr. Leary's office writes an individual letter to the secretary of each county within a reasonable distance of the scene of the meeting (see chart), asking him to pass the word to his members. He also writes a long letter to the host secretary, detailing the arrangements needed. When the secretary reports his place of meeting and other details and the school or hospital the names and subjects of the speakers, Mr. Leary puts it all together in a program, which is forwarded to Dr. Camp for printing. Seven copies in all of this program are sent out, to the local secretary, committee chairman and member for the district, the Councilor, etc.

Meanwhile an individual letter is written to each speaker, giving him instructions, travel routes, etc. He also prepares notices of the meetings for the Illinois Medical Journal and the Bulletin of the Chicago Medical Society, and finally prepares a news release which is sent to all daily and weekly newspapers in the counties previously notified of the meeting. (These figures are also on the chart).

Meanwhile Dr. Camp has the heavy tasks, first of sending a letter to each member in the counties covered inviting him to attend, and second of sending a copy of the printed program to each member, together with a return postcard addressed to the local secretary, indicating whether the member will attend.

The meetings are thus thoroughly publicized, through

#### POSTGRADUATE SUMMARY 1953-54

<i>Date</i>	<i>City</i>	<i>County</i>	<i>District</i>	<i>No. Spkrs.</i>	<i>Counties Covered</i>	<i>Releases Mailed</i>	<i>Faculty</i>
1953-54							
10-22	Sterling	Whiteside	2	3	8	94	Northwestern University
10-29	Jacksonville	Morgan	6	6	7	79	University of Chicago
11-12	Benton	Franklin	9	6	19	104	Michael Reese
11-19	Cairo	Alexander	10	5	11	73	Passavant Memorial Hosp.
11-19	Kankakee	Kankakee	11	9	8	114	Stritch—Loyola
12-10	Taylorville	Christian	7	5	15	142	V. A. Hospital
2-25	Effingham	Effingham	7	9	9	88	Stritch—Loyola
3-10	Rockford	Winnebago	1	7	8	75	University of Illinois
3-18	Carlinville	Macoupin	6	4	9	108	Cook Co. Grad. School
3-31	Moline	Rock Island	4	8	8	98	Presbyterian Hosp.
4-21	Waukegan	Lake	1	10	8	113	Chicago Med. School
4-22	Springfield	Sangamon	5	8	17	138	Wesley Memorial Hosp.
4-29	Mattoon	Coles	8	7	19	142	St. Luke's Hosp.
9-28	DuQuoin	Perry	10	3		46	
10-14	Eldorado	Saline	9	3		19	
11-19	Fairfield	Wayne	9	3		57	
3-30	Sycamore	DeKalb	1	3		21	
4-15	Kewanee	Henry	4	3		16	
4-30	Olney	Richland	8	3		19	

county societies, through personal letters, through copies of the program and through the lay press, as far as the state society's role goes. Local publicity varies widely—personal phone calls and other direct contacts, the interest of the wives, who are almost always invited and entertained, through local bulletins and often by a local mailing. It is by the sum total of all these efforts that the attendance at most meetings has been highly satisfactory.

The committee recommends that the program of postgraduate conferences be continued, both for their teaching value and for their organizational value. We believe that, with the cooperation of the Councilors and local county society officials, and with more intensive promotion, the one-man clinic using actual patients can be developed into a valuable teaching medium, though it cannot fulfill all the functions of the larger meetings. The smaller three-man conferences likewise have a real value and warrant further development.

We also reiterate the recommendation previously made—that the postgraduate program be planned out, at least as to the dates and places, in the early autumn. This will permit better promotion and better attendance and make the meetings even more valuable.

Finally, it is with regret that we end this report with the announcement that George A. Hellmuth, M. D., of Chicago, our chairman for three years, has decided to move to Milwaukee, where he is to head the cardiovascular division in Marquette University Medical School. The Society owes him much for his long and devoted service.

Respectfully submitted, GEORGE A. HELLMUTH, M. D., *Chairman*. N. C. BARWASSER, M. D., JACOB E. REISCH, M. D., J. H. MALONEY, M. D., GEORGE A. KIRBY, M. D., JOHN L. REICHERT, M. D., R. C. OLDFIELD, M. D., JOSEPH J. GRANDONE, M. D., F. W. SIEGERT, M. D., WILLIAM H. SCHOWENGERDT, M. D., N. A. THOMPSON, M. D., WILLARD W. FULLERTON, M. D., EDWIN F. NECKERMAN, M. D., MR. JAMES C. LEARY, *Secretary Committee on Postgraduate Education*.

#### COMMITTEE ON RURAL MEDICAL SERVICE

The past year has brought no dramatic developments in the field of Rural Medical Service in Illinois. Some new avenues for the distribution of information are being explored. An increasing number of rural young men are seeking loans for the completion of their medical education. The Hospital Construction Program under the Hill-Burton Act is virtually completed.

The Committee has done all it reasonably could to enlist the cooperation of constituent County Medical Societies in the support of Health Improvement Associations. These grass roots movements have certainly taken the place of Health Councils in approximately 70 counties within our state. The Health Improvement Association has done much to interest rural and small town citizens in health matters. Because each of these

associations is organized at the county level, they may do and have done a variety of things in the health field. Some associations educate nurses, others conduct tuberculosis surveys, others conduct brucellosis campaigns, and others conduct Grade A milk programs. They are certainly deserving of all the support that physicians within their county can possibly give them. Approximately 150,000 farm people are now joined in this fine movement.

The Farmer-Doctor Loan Fund Board program has progressed without interruption. Over 50 young men are now under contract to return to their home counties or some adjacent county in need of a practitioner. The provisions of the Doctor-Draft Law project two years into the future the return of many of these young men to their home counties to practice. Only one student has gone back on his contract. He went to another state to practice but paid the entire amount of his loan back to the Loan Fund Board. He has had so much trouble with arranging his medical affairs in that state because of his jumping a contract in Illinois that we anticipate no other loanee will try the same tactics. The farmers of Illinois think so well of the Loan Fund Board program that at the last meeting of their House of Delegates, they again appropriated \$50,000 to be used, if necessary, in this program.

Dr. G. C. Otrich represented the Committee at the Dallas meeting of the American Medical Association's Committee on Rural Health held March 4 through 6. Dr. Otrich reports that 500 persons attended this meeting, despite the bad Texas weather.

Dr. Otrich suggested to the group and to Secretary Benson that we raise the butter fat content of milk and leave in a bit more casein. Such a maneuver would certainly take care of the butter fat surplus. Dr. Otrich expressed the view that the milk processing plants for dairy products, rather than the producer, might have something to do with our surplus.

Dr. Otrich reported seeing a very fine film put on by the State Medical Society of Colorado concerning nurse recruitment. The problem of recruiting auxiliary medical personnel has been and will be with us for many years to come. It is the feeling of many that more physicians must interest themselves in the recruitment and education of auxiliary personnel.

Lack of teaching personnel, economic pressures, and ordinary human inertia may cause many hospitals in the rural part of Illinois to lose their nurses training schools. Our Committee feels that it is incumbent on all practitioners of medicine in the rural parts of Illinois to do everything possible to maintain a program of nurse education.

Extension Service of the United States Department of Agriculture, in cooperation with the Extension Services of the State Universities of Illinois and Nebraska and Alabama, has joined in an educational program. The Committee's chairman spent the entire day of March 26 at the State University in Urbana discussing this program with many others. Represented were the State Health Department, the Cancer Society, the

Heart Association, the Polio Foundation, and the Tuberculosis Association. Since 40% of the total population of the United States live in the country and in small towns, everyone agreed that a stepped-up educational program for all citizens was in order.

Following an all-day meeting of minds, it was generally agreed that any educational program attempted by the Extension Service of the University through the Farm and Home Bureaus would have to be general in context and free from the case finding type of approach. There will be further explorations of how this general information will be presented to our rural citizens. We have every reason to believe that in its final pattern there will be nothing in this educational approach that will be at all prejudicial to the position of the individual practitioner of medicine in Illinois. It is the chairman's feeling that out of this may come a fine type of cooperative effort that will be of great assistance to the public and of benefit to the profession.

Education for better health is and will be a continuing problem with our rural people. The assistance in recruitment and in education of physicians, as well as auxiliary personnel, is certainly a prime responsibility of all members of this Society. The Committee wishes to thank each member of the society for his suggestions and for the support we have received from virtually every member of the Illinois State Medical Society.

Respectfully submitted, HARLAN ENGLISH, M. D., *Chairman*. G. C. OTRICH, M. D., W. I. LEWIS, M. D., J. C. REDINGTON, M. D., *Committee on Rural Health*.

SCIENTIFIC SERVICE COMMITTEE

One hundred five programs were arranged by the Scientific Service Committee for fifteen county medical societies, one branch society and three district medical groups during the past year. Four of the county medical societies met jointly. In addition, notices of meetings were mimeographed and mailed as were news releases to the press. The following chart briefly tells the story:

<i>Society</i>	<i>Speakers</i>	<i>Double Postcards</i>	<i>Single Postcards</i>	<i>Press Releases</i>
Bureau .....	6	973		156
DeKalb .....	12	537		75
Greene .....	1	154		92
Henry .....	7	1011		122
Ill. Acad. Gen. Pr.				
Rock Is. Chapter .....	5			
Iroquois .....	3	65		23
Ia.-Ill. Cent. M. A. ....	2			
Kane .....	5			
Knox .....	8	443	435	159
LaSalle .....	11	1625		263
Logan .....	1		26	6
Macon .....	2			
Marion .....	7			100
McDonough .....		445		381

Montgomery-Macoupin ....	5	356	9	121
N. Cent. M. A. ....	1			
St. Clair .....	4		462	29
Stock Yards Branch .....	9			
Whiteside-Lee .....	16	1078		179
Total .....	105	6687	932	1706

Of the 105 speakers scheduled, twenty-five are for meetings beyond the period covered by this report.

The figures of work produced does not reflect the effort and time consumed in extending these services. Letters of invitation and confirmation are sent both speaker and program chairman. Numerous telephone calls, both local and long distance, are frequently necessary, and very often a number of physicians are contacted before one definite commitment is received. The mimeographing of the postcard notices is done by hand with a slip sheet being inserted between each card to avoid offset. A telephone call is made to each speaker to obtain permission to release a story to his neighborhood paper. The local publicity was approved by Council action and, with a few exceptions, has been welcomed by the speaker. News releases are sent not only to the newspapers in the county where the meeting is being held, but to several adjacent counties. After each meeting, societies are billed for the cost of postcards and are notified of the papers to which publicity was sent.

As always, there have been complaints that not all the membership of any one society is receiving postcard notices of the meetings. This stems from the failure of the program chairman or secretary to notify the Scientific Service Committee of membership changes. The Committee is cognizant of the fact that rarely a society's membership remains status quo for any given period. Changes occur, either by death, transfers or new memberships. For this reason, the Scientific Service Committee is dependent on the local society for up-to-date notification in order that proper corrections can be made in the mailing list.

The Chicago staff, responsible for the work of the Scientific Service Committee, is also responsible for multitudinous services to other committees. Recognizing this, secretaries and program chairmen can be assisted more rapidly by setting up programs well in advance. Last minute changes frequently necessitate a duplication of work already completed and create a hardship on an understaffed office.

Since the Committee invites only members of the Illinois State Medical Society, scientists in related fields, and members of the medical societies in fringe areas to Illinois, program chairmen and secretaries should be aware of this ruling by the Council when requesting service.

Reports received indicate that not all county medical programs are well attended. The Committee believes that its responsibility is to stimulate attendance, but concurs, too, in the idea that if the group is small, the speaker should feel that his message is going to a group of interested physicians who not only benefit from his presentation, but who would also disseminate the information.

In the past, there have been complaints about the lateness of the hour when the invited physician delivered his presentation. Frequently he had to sit through a long business session, which resulted in a late departure for his return home. There have also been complaints that projection equipment and blackboard were not available for the speaker's presentation, even though the information was contained in the letter of confirmation to the program chairman. To obviate misunderstanding, it is the policy of the Committee to send the program chairman and the speaker a copy of the letter to each.

The Committee held a dinner meeting at the Sherman Hotel, September 23, 1953, to discuss, principally, the work incident to the revision of the List of Speakers. Acting on the Committee's recommendation and Council approval, three notices appealing for speakers were published in the Illinois Medical Journal and bulletins of the county medical societies. Medical letters were sent to the deans of the five medical schools with a similar request. A total of 315 names were received in all, seventy-eight of which were new.

Single postcard confirmation was sent to each new speaker and, in addition, postcard questionnaires for new and up-to-date subjects and status of availability were sent to 928 persons listed in the Master File of the Speakers' Bureau of the Scientific Service Committee.

On November 2, the Chicago members of the Committee met in the Chicago office to review the material and outline classification of subjects, based on the recommendations of a sub-committee within the Committee, namely to use the Speakers' List format of the Ohio State Medical Association. There will be one deviation, however, in that addresses of physicians will not be included, since the Scientific Service Committee urges program chairmen and secretaries to channel their requests for assistance in programs through its office.

Because of the tremendous amount of work carried on by the Chicago staff, which is currently understaffed and without stenographic assistance, actual compilation and categorization has not been undertaken.

The death of Dr. J. J. Link, Mattoon, was a distinct loss to the Committee which so expressed itself in a letter of condolence to his family.

As indicated in the chart, service has been given to three medical organizations not county medical societies. This service has been approved by Council authorization, provided all expenses for the speakers are assumed by the organization. County medical societies are asked to assume expenses whenever possible. When local treasuries are not adequate, the expenses are borne by the Scientific Service Committee.

The Scientific Service Committee has fulfilled every task for which it is responsible. The Chairman has personally presented detailed reports of the Committee's activities of four sessions of the Council in the past year, copies of which went to each member of the Committee to keep them informed. Individually Committee members have participated in speaking appointments whenever requested.

The Chairman has visited the Chicago office weekly.

The Committee wishes to commend the Educational Committee for the efficient and conscientious services of its Secretary, Miss Ann Fox, and her assistant, Mrs. Kay Simmons. Without their loyalty and sincerity, the work of this Committee could not have been fulfilled. Even when stenographic assistance was not available, they fulfilled all their responsibilities.

The Scientific Service Committee submits this report as a graphic outline only of the numerous details necessary to serve the county medical societies whenever and however possible and as an expression of gratitude to the House of Delegates and the Council for their confidence.

Respectfully submitted, LOUIS R. LIMARZI, M. D., *Chairman*. J. K. HANSON, M. D., WILLIAM H. WHITING, M. D., GILBERT MARQUARDT, M. D., JEROME T. PAUL, M. D., MAX HIRSCHFELDER, M. D., HARRY A. OBERHELMAN, M. D., CHARLES D. KRAUSE, M. D., *Scientific Service Committee*.

#### COMMITTEE ON TUBERCULOSIS CONTROL

The meeting of the Tuberculosis Control Committee of the Illinois State Medical Society was held March 12, 1954, and the tuberculosis problem in the State of Illinois was discussed.

During the calendar year of 1953 the number of deaths from tuberculosis occurring among Illinois residents decreased approximately 21% when compared with the 1952 figures. The total number of deaths among Illinois residents, exclusive of Illinois residents dying outside of the state, was 1,210. Of this number 794 deaths occurred within the City of Chicago and 416 in the remainder of the state. The provisional death rate for Illinois from tuberculosis is 13.4 per one hundred thousand. Corresponding rates for Chicago are 21.4 per hundred thousand, and for downstate Illinois 7.7 per hundred thousand. This represents a decline for the state of approximately 22%. Of the total number of deaths in Illinois only 50 or 4.1% occurred among children under five years of age. Thus, only 16 deaths occurred among the population from kindergarten through high school age. The morbidity for the downstate area was 1,873 cases compared with 1,963 in 1952. No figures are on the Chicago morbidity. The available figures represent a ratio of approximately 4½ new cases of tuberculosis reported for each death occurring outside of Chicago.

The Department of Public Health operates two tuberculosis sanatoria. The 100 bed hospital at Mt. Vernon operated at about capacity throughout the calendar year. The hospital has a very active surgical service, in that it receives many surgical cases from the Alexander County, St. Clair County and Madison County Sanatoria. Throughout the year there has been a waiting list varying between 10 and 25 cases from southern Illinois.

The 450 bed State Tuberculosis Hospital in Chicago was dedicated October 11, 1953, and received the first patient on November 9, 1953. At the end of the cal-

endar year 58 patients were under treatment. Additional beds will be made available for the hospitalization of tuberculosis patients as rapidly as the problem of professional personnel is solved. Physicians and nurses are extremely difficult to obtain and the rate at which future beds will be made available must be largely dependent upon meeting these shortages.

It is estimated that approximately 1,200,000 x-rays were taken by mobile units operated by the Illinois Department of Public Health, the Chicago Municipal Tuberculosis Sanitarium Board in cooperation with the Tuberculosis Institute of Chicago and Cook County, the Cook County Suburban Tuberculosis Sanitarium Board, Lake, Kane, DuPage and Winnebago Counties and general hospital admission x-ray units throughout the state, including those in mental and penal institutions. This number represents slightly more than 13% of the entire population. The number of persons x-rayed could be considerably increased if the hospital administrators and the hospital staffs would make routine hospital admission x-rays more readily available. In some of the hospitals having 70 mm. units, apparently fewer than ten per cent of the total number of admissions received a miniature film during their hospital stay. In spite of the many articles which have been written by hospital administrators and roentgenologists, there appears to be lack of active interest in this program on the part of the members of the medical staffs. The varied pathology found by this simple procedure would seem to warrant its serious consideration by both administrators and medical staffs of all hospitals throughout the State of Illinois.

The report on tuberculosis beds in Illinois are as follows: Downstate—1,968; Chicago and Cook County—2,777; and Veterans Administrations—612 for a total of 5,357 hospital beds. This does not include any beds used for treatment in mental hospitals, nor does it include the new Suburban Cook County Tuberculosis Sanitarium which will open soon with approximately 200 beds. It is important to note that there are approximately 136 vacant tuberculosis beds in downstate Illinois.

While it is true that the morbidity rate in the State of Illinois is declining it has not kept pace with the decline in the mortality rate. Undoubtedly the increasing number of chest x-ray survey films, both in Chicago and downstate, have played an important part in the making of these statistics. With the increased number of chest survey films and the increased number of hospital admission films it is almost certain that most of the cases of tuberculosis will continue to be found in the early stages before transmission of the infection to other people has taken place. This will continue to reduce our morbidity as well as mortality rate. It may, therefore, be necessary for this committee to give some consideration in the future to the ultimate utilization of empty beds in tuberculosis sanatoria.

The Tuberculosis Legislation considered by the 68th Illinois General Assembly included the following bills:

Senate Bill No. 44: Appropriates \$89,910 to the University of Illinois for expenses of the Institute for Tuberculosis Research. Passed and approved. This is for the BCG research in which the Municipal Tuberculosis Sanitarium, the University of Illinois and the Institute for Tuberculosis Research are cooperating.

Senate Bills Nos. 221, 222, 223, 224, and 225: A series of bills designed to protect the public against the spreading of tuberculosis by active cases who refuse isolation and hospitalization. The bills passed both houses without a dissenting vote, and were recommended to the Governor by his own Advisory Committee on Tuberculosis. The Governor vetoed the Public Protection Law and recommended that further efforts should be exerted by the official agencies and medical profession to educate the recalcitrant patient. It is recommended that this law be presented again to the legislature for passage and every effort made to persuade the Governor to sign it.

Senate Bill No. 290: Proposed to create a Tuberculosis Commission of three senators, three representatives, three persons appointed by the Governor, and the Director of Public Health and Public Welfare ex-officio, to study all aspects of the tuberculosis problem in Illinois and report to the next session of the legislature. It carried a \$10,000 appropriation provision. This bill was passed by the legislature and vetoed by Governor Stratton who said in part: "This is an activity which falls naturally within the scope of the duties of the Department of Public Health." This committee believes that the Governor's Tuberculosis Advisory Committee (appointed June 18, 1953), was a suitable substitute for the above commission.

Senate Bill No. 291: Fixes tax for the Municipal Tuberculosis Sanitarium at 5½ million dollars for 1954 and 1955, and 5¼ million dollars for subsequent years. This bill also permits payment for care of patients in other tuberculosis facilities, even those outside of the state, when no facilities are available in Chicago or nearby counties.

House Bill No. 228: Permits the Department of Public Health to hospitalize tuberculosis patients who have no legal county or municipal residence, altho they have been in the State of Illinois for one year. Passed and approved.

House Bill No. 229: Permits the Department of Public Health to pay up to \$4.00 (formerly \$3.00) per patient per day to local tuberculosis authorities whose funds are inadequate to care for their hospitalized cases. In determining adequacy of funds, local authorities may spend up to 10% of their local tax revenue for alteration, repair, expansion, maintenance, etc., of their facilities. The Department may use up to 5% of its aid funds in hardship areas. This bill also abolishes the \$6.00 per diem maximum, and permits the Department to relate charges to costs. Passed and approved.

House Bill No. 496: Increased the Cook County Tuberculosis Board from three members to five. Passed and approved.

Senate Bill No. 557: Permits county boards to vote

excess tax for tuberculosis for an indefinite period, thus eliminating the necessity of revoting the tax from time to time passed and approved.

The Municipal Tuberculosis Sanitarium reports that its waiting list has been cut from 602 in January, 1953, to 186 as of December 31, 1953. The number of beds has been increased by forty at the Municipal Contagious Hospital where all the cases of children's tuberculosis are now cared for, giving an additional 40 beds for adults at the north side sanatorium. These results were obtained largely by change in discharge policy and the setting up of an outpatient chemotherapy program. Under this program one thousand patients have received antimicrobial therapy in the clinics and approximately 600 are under treatment there currently.

Beginning in August, 1953, the Medical Directors of the public tuberculosis sanitariums in Chicago met and set up a cooperating program directed towards the elimination of re-duplication. A single waiting list has been set up for all Chicago residents who require hospitalization at the Municipal Tuberculosis Sanitarium, the Cook County Tuberculosis Sanitarium, or the Chicago State Tuberculosis Sanitarium.

The Municipal Tuberculosis Sanitarium has taken definite steps to install x-ray equipment in the Bridewell for the x-raying of all inmates and personnel.

Ground breaking for the new 154 bed Suburban Cook County Tuberculosis Sanitarium took place on May 12, 1953. It is anticipated that the hospital will begin operation late in the Fall of 1954. The Suburban Cook County Tuberculosis Sanitarium District has never had a waiting list since it began operation, being able to hospitalize all of its known cases in nine nearby private and public sanatoria. The daily average census rose to 213 in 1953 as compared with 204 in 1952. Case finding programs have been extended and the District now maintains eight clinics in the Suburban Cook County area.

For several years the Tuberculosis Control Committee of the Chicago Medical Society was active in planning legislative programs and seeing them through the legislature. Responsibility for this was largely when the Mayor appointed an over-all coordinating committee. This committee was made up of representatives from the State Legislature, City Council, Labor, the Civic Federation, the Welfare Council, the Women's Organizations, various tuberculosis agencies and the Medical Society. This committee speaks for practically the entire community. Its approval of a program means that almost none is left to oppose it, consequently the Tuberculosis Control Committee has been made less active in the past year. It has now assumed a stand-by position.

A luncheon meeting was held during the 1953 annual meeting of the Illinois State Medical Society. This luncheon was attended by seventy-five physicians, most of whom were members of their component medical society—Tuberculosis Control Committees. The group was addressed by Dr. Jay Arthur Myers who outlined the necessary steps toward the complete eradication of

tuberculosis. The ultimate program would be to skin test the entire population and x-ray all the positive reactors every year thereafter. The feasibility of this project for the State of Illinois seems to be nearer than at any time in the last fifty years.

A similar luncheon is to be held at the 1954 annual meeting of the Illinois State Medical Society. This luncheon is to be held in conjunction with the Illinois Chapter of the American College of Chest Physicians.

The following specific recommendations are made by the committee for consideration by the House of Delegates of the Illinois State Medical Society:

1. The Illinois State Medical Society again endorses the survey method for the control of tuberculosis and recommends the use of this method to all County Medical Societies. It also recommends that follow-up 14 x 17 films by the survey agency be encouraged in order that the full value of the survey may be obtained.

2. The Illinois State Medical Society again recommends that the House of Delegates go on record as endorsing the policy of routine chest x-rays for all admissions to hospitals in the State of Illinois.

3. The Illinois State Medical Society endorses the principles embodied in the Public Protection Laws, Senate Bills Nos. 221, 290, 291 and House Bills Nos. 228 and 229, as passed by the 68th General Assembly of the Illinois Legislature.

4. The Illinois State Medical Society wishes to again extend its support and recommends the support by its component County Societies to all the governmental and voluntary agencies who are cooperating to effect the eradication of tuberculosis.

5. The Committee recommends that the House of Delegates request that every County Medical Society in the State of Illinois have a tuberculosis committee and that the Secretary of the Illinois State Medical Society should be informed of the members of these committees.

Respectfully submitted, GEORGE C. TURNER, M. D., *Chairman*, CHARLES PETTER, M. D., DARRELL TRUMPE, M. D., WILLIAM BRYAN, M. D., JAMES H. HUTTON, M. D., BERNARD KLEIN, M. D., *Committee on Tuberculosis Control*.

#### COMMITTEE ON VOLUNTARY PREPAYMENT PLANS FOR MEDICAL AND SURGICAL CARE

The last year has been another year of growth and development in the field of voluntary prepayment insurance against the costs of illness. That is one of the most important, in fact, triumphant, reports made to the House this year, for it can never be too emphatically stated that the fullest and broadest voluntary insurance coverage possible is also our best insurance against the socialization of medicine. For that reason, we again urge every member to do all he can to encourage patients to buy and maintain whatever insurance fits his pocketbook and the needs of himself and his family.

At the same time it should be made equally clear that insurance is designed to help people pay their medical

bills, not as a reason for the physician to increase his charges. The purposes of insurance are defeated when any physician adopts that attitude. It is true, however, that there is a definite increase in complaints to county society grievance committees in which insurance is a factor—complaints from both patients and insurance companies regarding high fees.

## THE ILLINOIS PLAN

There have been no changes during the year in the list of commercial carriers offering medical and surgical expense policies approved for participation in The Illinois Plan. One company has offered a new series of contracts, however, and these are still under scrutiny; it is expected that some changes will be required to make them acceptable for the Plan.

Unfortunately no figures for the year are available as this is written, but it is estimated that approximately one-tenth of the 5,000,000 or more Illinois residents who have some form of medical and/or surgical coverage hold their policies from carriers participating in The Illinois Plan. If efforts to obtain these figures are successful, they will be presented in a supplementary report to The House of Delegates.

## THE BLUE SHIELD PLAN

The Board of Trustees of the Illinois Medical Service (Blue Shield) report the following figures for December 31, 1953:

Total membership .....	930,014
Added in 1953 .....	139,528
Percentage Increase .....	18%
Income from Members .....	\$8,464,911
Benefits Paid (to M. D.'s) .....	\$6,102,968
Members involved .....	115,679
Operating Costs (Dec. of 1%) ....	10.59%
Assets .....	\$6,539,262
Increase in 1953 .....	\$1,790,170
Percentage of Increase .....	38%
Reserve (unallocated) .....	\$4,391,767
1953 Increase .....	\$1,585,145
Per member .....	\$ 4.72

The 1953 payments to physicians amounted to 40% of all the \$15,702,711 paid them since 1947, when the Plan was organized.

The Blue Shield Plan at Rockford had 52,164 members as of December 31, 1953, including 20,004 subscribers and 32,160 dependents. It had 6.1% of the 850,000 population of its area enrolled, up from 4.9% a year previous. Its assets totalled \$187,850 and reserves \$93,695. Its total income was \$333,253, of which it paid out \$252,395 in medical and surgical benefits. Operating expense was \$55,228 or 16.57%.

At Moline and Alton the Blue Shield groups showed similar progress.

Moline had 24,658 members, 10,333 subscribers and 14,325 dependents. It was serving 18.5% of its 133,500 area population, up from 15.83% the previous year. Assets totalled \$99,763 and reserves \$47,400. Total income was \$238,366, of which it paid out in benefits \$198,287. Operating expense was \$31,625 or 13.3%.

Alton had 18,510 members, 8,046 subscribers and

10,464 dependents. It was serving 3.49% of its 530,442 area population, compared with 2.38% in 1952. Assets totalled \$80,161 and reserves \$43,752. Total income was \$147,604, of which it paid out \$105,895, at an operating cost of \$30,500 or 20.66%.

Illinois thus had 1,025,346 of its citizens on the medical/surgical expense rolls of Blue Shield plans alone. No current figures are available for private carriers, although it is estimated that the total would be much higher.

It has been estimated recently that more than 100,000,000 persons or nearly two-thirds of our total national population, are covered by some form of voluntary prepayment insurance. It is clear, therefore, that Illinois is carrying its share of the task. But that optimistic note will be warranted through the next year only if we all do our share in promoting further expansion.

Respectfully submitted, PERCY E. HOPKINS, M. D., *Chairman*, WARREN W. FUREY, M. D., *Vice Chairman*, EDWIN S. HAMILTON, M. D., JACOB E. REISCH, M. D., DAVID B. FREEMAN, M. D., JOSEPH S. LUNDHOLM, M.D., THOMAS J. KELLY, M. D., *Ex-Officio*: WILLIS I. LEWIS, M. D., F. LEE STONE, M. D., HAROLD M. CAMP, M. D., *Committee on Voluntary Prepayment Plans*.

DR. HOPKINS: I have a supplementary report. TO THE MEMBERS OF THE HOUSE OF DELEGATES:

At the time of writing the report contained in the HANDBOOK figures were not available as to the number of contracts in force provided by private insurance carriers. Such information is now available and it is estimated that there are about 210,840 subscriber contracts with 315,355 dependents, making a total of 526,195 people covered by private insurance carriers in Illinois as of this date.

Respectfully submitted, PERCY E. HOPKINS, M. D., *Chairman*, WARREN W. FUREY, M. D., *Vice-Chairman*, EDWIN S. HAMILTON, M. D., JACOB E. REISCH, M. D., DAVID B. FREEMAN, M. D., JOSEPH S. LUNDHOLM, M. D., THOMAS J. KELLY, M. D.

## ADVISORY COMMITTEE TO THE WOMAN'S AUXILIARY

Your Advisory Committee to the Woman's Auxiliary has had two meetings with the present group of officers and has maintained a continual correspondence with them in reference to their problems which have ranged all the way from problems of finance to a selection of a proper speaker. We have found the present officers to be most understanding and anxious to fulfill the tradition that our Auxiliary is the most effective and beneficial public relations arm of the profession.

The Auxiliary has been most cooperative in helping out on all of the projects of the State Society wherein their help has been requested. A problem which previously plagued the Auxiliary, namely, the continuation of their publication "Auxiliary News" has been satis-

factorily solved. Quite generously Mr. Web Johnston of the Commercial Art Press, Monmouth, has sponsored the publication of this news sheet with the result that all doctors' wives of the State of Illinois have been enabled to keep in touch with the Auxiliary and Medical Society doings. This has been a welcome and generous gesture on the part of the sponsor making this possible and we desire to extend our thanks to him at this time.

Among their new projects was the publication of a membership roster for the current year, bringing the same up to date and including a list of their members-at-large. These are doctors' wives coming from counties wherein no organized county society auxiliary exists. We would call to the attention of all members that it is now possible for their wives to become Auxiliary members whether or not they themselves reside in a well-organized area. The Auxiliary also cooperated with the Medical and Surgical Relief Committee in collecting and forwarding for the use of needy medical men in Europe, surplus medical supplies, instruments, dressings, drugs and so forth.

They have also experimented this year with a new method of promoting "Today's Health" through contacting and utilizing the service of the Girl and Boy Scouts. They have in addition established a working relationship with the Committee on Mental Health of the AMA, having one of their representatives meet with them as an observer.

One of their most telling pieces of work has been in the field of nurse recruitment under the chairmanship of Mrs. Edwin S. Hamilton. This Committee has been most successful in pointing up this need and in recruiting new students. Other activities and interests of the Auxiliary have been equally notable. For the detailed story reference must be made to the report of their capable President, Mrs. Henry Christiansen which will be found elsewhere in this volume.

I believe our Auxiliary is on firm ground and your Committee desires to commend their present officers for their enthusiastic activity in guiding the affairs of their organization. The Council of the State Society has been most helpful to the Committee with their understanding viewpoint for which each Committee member is grateful.

Respectfully submitted, H. KENNETH SCATLIFF, M. D., *Chairman*, WARNER H. NEWCOMB, M. D., C. PAUL WHITE, M. D., H. CLOSE HESSELTINE, M. D., HAROLD M. CAMP, M. D., *Advisory Committee to Woman's Auxiliary*.

#### REPORT OF THE WOMAN'S AUXILIARY

The Woman's Auxiliary to the Illinois State Medical Society is completing the first year of its second quarter century of existence. I should like to give you a report of Auxiliary activities during the past year.

We now have auxiliaries in thirty-nine counties with Cook County having eleven branches and St. Clair County two. Two new Counties, Perry and Stephenson were organized and Livingston reactivated. In addition

to the organized counties, we have active representation in twenty-five more counties through our members-at-large. We have at the present time two thousand three hundred and fifty members.

We have placed special emphasis this year on what we considered two very important items, namely: Public Relations and Nurse Recruitment.

Public Relations work under the direction of our Second Vice President and Public Relations Chairman, Mrs. R. E. Davies of Spring Valley has gone forward into many fields, some of which I would like to record. (1) Held joint meetings with dental auxiliary and lawyer's wives at which a speaker was presented by the Auxiliary on a legislative topic. (2) Distributed A. M. A. Public Relations Handbooks, "Winning Ways with Patients," to Doctor's stenographers. (3) Helped with Blood Banks, Cancer Society, Mother's March on Polio, Heart Association, participation in Gamma Globulin program, and so forth. We have teachers in Home Nursing, First Aid and Nutrition. One county made a survey on volunteer work done by Auxiliary members and found that there was a member either serving on the Board or as a volunteer worker of each health agency. We are making an effort to prove to the public that health is our greatest concern.

Nurse Recruitment Chairman, Mrs. Edwin S. Hamilton has worked diligently to stimulate Nurse Recruitment in the counties. I feel that we have had a fair measure of success. Eleven counties are sponsoring Future Nurses Clubs with more in the process of being formed. More than two thousand prospective students have been contacted, and while the end of the school term is still several months away, they have a fair percentage of known recruits.

Fourteen counties are giving either loans or scholarships to nurses. The scholarships range from one hundred dollars to a full tuition.

The promotion of "Today's Health" has been approached from a different angle this year and we have succeeded in increasing the number of subscriptions to the non-medical groups.

Our interest in Benevolence has been maintained. In addition to the one dollar allocated from dues, further contributions have been made by the counties. The total amount to date is around forty-five hundred dollars.

I wish to thank our advisory committee composed of Dr. Warner H. Newcomb, Dr. C. Paul White, Dr. H. Close Hesseltine, Dr. Harold Camp and Dr. H. Kenneth Scatliff, Chairman. All matters of policy have been submitted to them and their advice has been closely followed.

We are indeed grateful to the State Medical Society for their financial aid. This has been given in the way of printing, mimeographing, mailing of "Auxiliary News Letter" and Convention money. Without this help it would be impossible for us to operate on our present budget.

I have visited twenty-eight of the organized counties during the year and have found a splendid spirit of co-

operation. We are making progress in our aim to cultivate friendly relations and promote mutual understanding among doctors' families.

Respectfully submitted, MRS. HENRY CHRISTIANSEN, *President, Woman's Auxiliary.*

#### COMMITTEE ON DIABETES

A meeting of the Committee on Diabetes of the Illinois State Medical Society was held September 17, 1953, at 12:00 noon, University Club, Chicago, Illinois.

Those in attendance were: Robert W. Keeton, M. D., Chairman; T. D. Masters, M. D., Member; George M. Parker, M. D., Member; Willard O. Thompson, M. D., Member; F. Lee Stone, M. D., Chairman of the Council; Harold M. Camp, M. D., Secretary, Illinois State Medical Society; Editor, Illinois Medical Journal; Theodore R. Van Dellen, M. D., Associate Editor, Illinois Medical Journal; Henry T. Ricketts, M. D., Member of the Council, American Diabetes Association.

Dr. Henry Ricketts opened the discussion from the viewpoint of the American Diabetes Association. It was his feeling that the drives had been progressively successful. He noted that the Chicago Diabetes Association had been lukewarm with reference to it, perhaps in part due to the extra work entailed in its organization. His interest in it had increased of late because of the definite educational value of the effort to the public and to the doctor.

Dr. Masters presented a very interesting report on the diabetes detection drives which had been held the last four years in Springfield. He noted that there was a tendency for the community to tire of the drive and become less cooperative. The number of urine examinations originating from drug stores was negligible. The doctors had been most successful in their publicity drive. The cooperation of captive audiences, such as school children and workers in factories was good, but after all the workers in the factories were examined periodically and there was a little hesitancy on the part of the medical staff of the industries to repeat in a short time the tests which they were making at regular intervals. He pointed out the good response of individuals in attendance at the State Fair. The examination of the urine at the State Fair was sponsored by the State Health Department in their exhibit. He regarded this as a highly successful venture. The exhibit has since been shown in a number of County Fairs, and a similar opportunity has been offered for the examination of specimens of urine at these showings. No figures have been released as yet.

As a result of the discussion, there seemed to be a reluctance on the part of those present to advise an "all out detection drive" by each County Medical Society.

The possibility of organizing lay diabetes associations in the various counties, which would cooperate with the physicians in organizing drives and promoting educational work, was discussed. Dr. Ricketts pointed out the genuine difficulty in keeping such groups interested. The Chicago Diabetes Association had found the Children's Summer Camp most effective in capturing their

attention and in furnishing them an objective for their energy.

After further discussion the following plan of action was proposed:

1) That no attempt be made at present to organize lay diabetic associations in the various counties.

2) That Dr. Ricketts be requested to write an editorial for the Illinois Medical Journal, covering the National Detection Drive. This appeared under the title "Diabetes Week," Vol. 104, p 331, Nov. 1953.

3) That Dr. Cross be requested to prepare a report detailing the experience of the State Health Department in the successful detection drive during the State Fair. This was prepared by Dr. G. Howard Gowen under the title "Screening for Diabetes," and appeared in the Illinois Medical Journal, Vol. 104, p. 293, Nov. 1953.

4) That the Secretaries of the various County Medical Societies propose to their respective societies that the State Health Department be invited to hold detection drives at the time of the County Fairs under the sponsorship of the County Societies. The Health Department has suggested that if this request is received, those counties would be selected in which a local Health Department exists. The personnel of the Health Department would be asked to assume responsibility for the details of the drive.

This plan is now being presented to the various Secretaries.

Respectfully submitted, ROBERT KEETON, M. D., *Chairman*, T. D. MASTERS, M. D., GEORGE M. Parker, M. D., W. O. THOMPSON, M. D.,\* *Committee on Diabetes.*

\*Deceased.

#### COMMITTEE TO INVESTIGATE CORONER'S OFFICE

Your Committee for the Revision of the Coroner's Act of the State of Illinois has investigated the possible ways by which the Coroner's System as now in force in the State of Illinois could be changed into a Medical Examiner System. The abolishment of the Coroner's System and replacement by the Medical Examiner System through Constitutional Amendment seems to be too difficult a procedure. Accordingly, the Committee has been advised that the present Coroner's Act can be defined by Legislative means so that the archaic practices now in effect will be replaced by the methods used in the Medical Examiner System. Such a proposed bill has been prepared and a preliminary hearing before the Senate Committee was held in Springfield last May. Lack of time for further discussion of the proposed bill at that time precluded the introduction of this proposal for actual consideration by the Legislature. The Committee has continued its efforts toward bringing a well considered proposal to the State Legislature at the session. Contact has been made through the Institute of Medicine of Chicago with the Chicago Bar Association and other law enforcement groups of the City of Chicago and the State of Illinois. The content of the proposed bill will be scrutinized by these groups in

order to meet their approval and satisfy possible objections.

The realization of such a medico-legal improvement in the administration of social and criminal justice in the State of Illinois demands concerted effort by all of our professional groups as well as other groups. It would be a great improvement over present practices and will reflect credit to all who actively participate in the accomplishment.

Respectfully submitted, EDWIN F. HIRSCH, M. D., *Chairman*, HARLAN ENGLISH, M. D., S. A. LEVINSON, M. D., C. PAUL WHITE, M. D., MR. JOHN NEAL, *Legal Adviser*.

#### INTERPROFESSIONAL RELATIONS COMMITTEE

The Interprofessional Council now consists of the representatives of the Illinois State Medical Society, Illinois State Dental Society, Illinois Optometric Society, Illinois Pharmaceutical Association, Illinois Veterinary Medical Association, and during the past year the Illinois Association of Chiropodists has been added to the Illinois Professional Council.

The annual meeting of the Illinois Interprofessional Council was held at the Sheraton Hotel on November 15, 1953. Senator George Drach of Springfield talked to the group on "Socialism and Ethics" and Dr. Glenn Moore of the Illinois Optometric Society talked about the growth and development of the Interprofessional Council.

This Council has had very interesting monthly meetings and has discussed all problems relating to joint interests of the professions.

During the course of the year the Constitution and By-Laws of the association have been developed and sent back to all of the affiliated groups for adoption by the Council of the groups.

Plans for activation of the council into districts in 20 of the larger Illinois towns have been formulated jointly. The committee has made plans for interchange of convention privileges between professions and holding joint social and professional meetings open to all of these groups. At several of the conventions it has presented a panel given by Dr. Harry Hedge representing medicine, Dr. Earl Boulger representing dentistry, Dr. R. D. Barton representing optometry, Mr. Ralph A. Carpenter representing pharmacy and Dr. Philip R. Brachman representing the chiropodists. These panels and speakers have presented the problems of the professions at joint meetings of affiliated groups.

One of the achievements of this group is an exhibit for the state conventions. This exhibit will be displayed at the annual meeting at the Hotel Sherman this year.

The medical representatives in this Council feel that this interchange of problems between professions will strengthen the unity of the professions against the increeping of socialism and heartily recommends to the council and the delegates of the Illinois State Medical Society the continued total participation in the medical profession and the extension of this program to the grass roots area.

Many problems of mutual interest to all professions are being acted upon jointly and I am sure that the report next year will bring a very favorable comment of unity in all respects.

Respectfully submitted, WAYNE B. SLAUGHTER, M. D., *Chairman*, F. M. HAGANS, M. D., JAMES H. HUTTON, M. D., HARRY M. HEDGE, M. D., ELLIOTT P. BURT, M. D., E. A. PISZCZEK, M. D., M. P. H.,

#### COMMITTEE ON CARDIOVASCULAR DISEASE

DR. W. H. NEWCOMB: I am presenting a new report from this Committee, since the one in the HANDBOOK contained typographical errors.

A Cardiovascular Section has been added to the Illinois State Medical Society. The first meeting of this Section was held at the annual meeting of the State Medical Society, last May, 1953. Dr. James Walsh, Chairman, and Dr. Wright Adams, Chicago, Secretary, arranged a well balanced program, which was well attended. Those in attendance remained throughout the program. Dr. Wright Adams, Chicago, was elected Chairman and Dr. Thomas Austin, Secretary, for the 1954 session. The Committee on Cardiovascular Disease met November 22, 1953, to discuss clinics for rheumatic and congenital heart disease. Dr. Wright Adams, Dr. James Walsh, Dr. Warren Pearce, of the Committee, were present. Dr. Harvey, Acting Dean of the University of Illinois College of Medicine, and Dr. Kobes, Director of Division of Crippled Children, University of Illinois, were also present.

Dr. Kobes outlined the activities of the Division of Service for Crippled Children in reference to rheumatic fever. This program has been in existence for Illinois since 1942. Adequate services for children with rheumatic fever are available in Chicago, but not for rural Cook County and the state as a whole. Rheumatic fever service is now available in Effingham, Chicago Heights, Elmhurst, Alton, where service has been established through the Madison County Heart Chapter of the Illinois Heart Association. The established clinics are diagnostic but seldom do the physicians accompany the patient, although reports are sent directly to the referring physician. Teaching clinics should be more beneficial to the patient, to the physician and to the Rheumatic Fever Control program. Congenital heart disease may likewise be readily found. The family physician should be taught if he is not already trained to recognize congenital heart disease, and rheumatic heart disease cases. One member of the Committee stated that congenital heart disease could be diagnosed by physical examination, at least the cases needing further study could be determined. Have the family physician screen cases before referral to the clinic.

Specialized clinics focus attention upon specific diseases; however, many cases of congenital and rheumatic heart disease are being found through the clinics held throughout the state by the Crippled Children's Service. The cases found through these clinics, come for the most part from indigent families and can be given

hospital service through this agency. Dr. Kobes stated that the Division of Crippled Children could not extend the existing service. Clinics held by other agencies would augment this service. Personnel from the Division of Crippled Children should be present so that activities could be coordinated.

The Illinois Heart Association has offered the services of an internist and pediatrician for clinics to be held in a few areas throughout the state. These clinics are not to be over four in number for this year, are to come to the various communities at the request of Local County Medical Societies. Personnel from the Division of Children should be present so that proper records may be kept, so that indigent cases may be properly referred for treatment. The Illinois Heart Association proposed to finance these clinics which will include per diem fees to the clinicians as well as transportation. The proposed clinics to be held by the Illinois Heart Association are to be diagnostic and not for treatment. Should hospitalization be necessary these cases would be referred to the Division of Crippled Children. It was stated that the Rehabilitation Center in Chicago is not yet established. If Rehabilitation Centers are established in the state many of these cases of congenital and rheumatic heart disease could be disposed of through Rehabilitation Centers, although Rehabilitation Centers for the most part do deal with adults.

The rheumatic fever program is: (1) Prevention. Control of streptococcal infections; (2) education of physicians for diagnosis and treatment; (3) providing the facilities for diagnosis and treatment; hospitalization and convalescence facilities; (4) Rehabilitation program for those who have recovered. Such a program can be carried out by private physicians, except service for the indigent patient requiring prolonged and special hospital care.

Respectfully submitted, WARNER H. NEWCOMB, M. D., *Chairman*, WRIGHT ADAMS, M. D., WARREN PEARCE, M. D., JAMES A. WALSH, M. D., LOUIS N. KATZ, M. D., GEZA De TAKATS, M. D., *Committee on Cardiovascular Disease*.

THE PRESIDENT: This new report will be given to the Reference Committee "C".

#### FIFTY YEAR CLUB COMMITTEE

The Fifty Year Club was authorized by the Illinois State Medical Society in 1938. All physicians who have practiced medicine 50 years, and are recommended by their county medical society in whose jurisdiction they reside are eligible. No initiation fee or dues are exacted. Up to the present time more than 950 physicians have been inducted into the Fifty Year Club.

For several years, invitations have been sent out to every living member to attend a complimentary noonday luncheon given by the Illinois State Medical Society. Last year approximately 135 attended this luncheon. Of this number there were approximately 95 physicians and 40 ladies. Among our honored guests were the President and Secretary of the American Medical Association. Many of the members attending this lunch-

eon come from distant states to meet their old friends, and discuss their school days and experiences during their 50 and more years of practice.

At the present time, we have approximately 425 members and it is rather remarkable that almost one-fourth of them attend our noonday luncheons. Of the six physicians who have received the State Society's award for being the outstanding general practitioner of the year, five of them are members of the Fifty Year Club.

Although more than one-half of the physicians in the state reside in the city of Chicago, approximately three-fifths of the members of the Fifty Year Club live downstate compared with the two-fifths that live in the city of Chicago. There are two possible reasons for this—one is that we have better physicians downstate than in Chicago or that the sanitary and outdoor life is more conducive to longevity.

Respectfully submitted, ANDY HALL, M. D., *Chairman*, E. H. OCHSNER, M. D., E. E. DAVIS, M. D., JULIUS H. HESS, M. D., *Fifty Year Club Committee*.

#### ADVISORY COMMITTEE TO AMERICAN LEGION, DEPARTMENT OF ILLINOIS

This Committee was appointed by our President, Willis I. Lewis, in 1953. Two meetings have been held, the first one taking place in Chicago in August, 1953, and the second one in Indianapolis, Indiana, on March 21, 1954.

The purpose of these conferences was the discussion of the "established policy concerning veterans' medical care, particularly as it refers to non-service connected disabilities which was recommended by the House of Delegates in June, 1953." The recommendation under discussion was that "all of the facilities of the American Medical Association and its constituent state and component county societies be employed immediately to disseminate background information and accurate statistical data in this regard." It was urged that "every effort be made to inform the profession and the public concerning the nature of the problem, the position of the American Medical Association and the reasons on which that position is predicated."

The membership of the conferences were representatives from six states called the "Central States Conference on Veterans' Medical Care" and Illinois was one of the states participating. The others were Kentucky, Indiana, Michigan, Ohio, and Wisconsin.

An interesting panel discussion took place at the Indianapolis meeting in March. One of the topics was "Who and What are We Discussing?" and was led by Mr. C. Joseph Stetler, Secretary, Council on National Emergency Service. Another topic was the "A. M. A. Policy and What It Means," which was led by Russell B. Roth, M. D., Member, Committee on Federal Medical Services, Erie, Pennsylvania. The third topic for discussion was "What Do Central State Physicians Think?" which was led by Maurice E. Glock, M. D. of Fort Wayne, Indiana. Louis M. Orr, M. D., presided as Conference Chairman. Dr. Orr is the Chairman of

Committee on Medical Service and comes from Orlando, Florida. He also gave a summation at the close of the meeting and recommendations.

The three principle points of the A. M. A. policy recommendation brought out in the discussion were:

1. That service connected cases should receive medical care in V. A. Hospitals.

2. That T. B. and Neuro-psychiatric non-service connected cases—illnesses which are usually of long duration—should receive V. A. Hospital care on a temporary basis and be terminated as soon as the State or Community could assume full responsibility for their care.

3. That other non-service connected cases should remain in local communities to be treated as any other local citizen. If indigent, they should receive care through the State, County or local assistance in the same manner as any other indigent person.

Some of the State representatives brought out the fact that it would be impossible to carry out the mandates of these recommendations due to their large unemployment situation, their limited or non-existing financial resources in their communities or the lack of other proper facilities.

It is obvious, of course, that anything so controversial, relating as it does to the welfare of millions of our citizens, will present problems and perhaps never resolve itself into a completely happy solution for all concerned.

The greatest opposition to the proposed plan comes from the American Legion. They maintain that the "Veterans Administration hospital system was designed to meet the needs of those who are disabled from service-incurred disabilities and for those whose disabilities have not been adjudicated as disabilities due to service and who cannot reasonably afford to pay for such hospital care elsewhere." They further state that "most non-service cases have mental illness, tuberculosis, cancer, heart disease, epilepsy, diabetes, arthritis, and other chronically disabling diseases" which have already by their very nature, necessitated hospital care in their own communities, exhausting their financial means;—that bed space is already limited in the local areas—that if these cases were declared indigent it would still be the taxpayer who would be paying the bills. To add to this, the Legion says that local communities are not prepared to provide adequate treatment for these long term cases;—that it is in the interest of economy that such cases be grouped for best possible treatment.

This, then, is the pro and con of the recommended policy of the House of Delegates.

Your Chairman wishes to thank Dr. Lewis for the privilege of serving on this important committee with such fine members.

Respectfully submitted, NORMAN L. SHEEHE, M. D., *Chairman*, WALTER C. BORNEMEIER, M. D., JACOB E. REISCH, M. D., JAMES A. WEATHERLY, M. D., *Advisory Committee to American Legion, Department of Illinois*.

#### LIAISON COMMITTEE ON MEDICAL EDUCATION

At the annual session of the American Medical Association in June, 1953, Dr. John Cline of California presented a report relative to the elimination of the stigma of "cultism" from osteopaths. He told of the laws of California pertaining to the medical care in that state which provided that in all tax supported hospitals osteopaths have the same rights and privileges as do graduates of medical schools. This means, according to Dr. Cline, that medical graduates must work with graduates of osteopathic schools and this could be considered a breach of medical ethics unless the cultist designation was removed.

The matter was discussed by the A. M. A. Board of Trustees and the House of Delegates which bodies recommended that no action be taken until the regular annual meeting which will be held in San Francisco in June, 1954. The Board of Trustees and House of Delegates recommended that this matter be discussed in meetings of every state society and that they in turn obtain opinions from their county medical societies.

In January, 1954, the Council of the Illinois State Medical Society appointed a committee known as the Liaison Committee on Medical Education. The purpose of this committee was to obtain the opinions of the respective county medical societies of the State of Illinois and to report these views to the 1954 annual session.

The three questions which were referred back by the Board of Trustees and the House of Delegates of the A. M. A. to the state and to the county societies are:

1. Should modern osteopathy be classified as "cultist" healing?

2. Since the objectives of the A. M. A. include improvement of undergraduate and postgraduate education, should doctors of medicine teach in osteopathic schools?

3. Should the relationship of doctors of medicine to doctors of osteopathy be a matter for determination by the several state associations?

In order that the Liaison Committee on Medical Education might better evaluate the answers and to obtain comment, a fourth question was added as follows:

4. If the Council on Medical Education of the A. M. A. (or an agent or agency acceptable to it) approved one or more of the osteopathic schools as having educational standards comparable to class "A" medical schools and the graduates of these schools adhered to medical practices and ethics comparable to that of doctors of medicine would you classify these osteopaths as cultists?

These questions were sent in letter and in questionnaire forms along with a page of general information to the president and secretary of each county medical society, to each branch of the Chicago Medical Society and to the officers and councilors of the Illinois State Medical Society. Part of the general information was given above. However, other points are listed now. Osteopathy was founded in 1874. At the present time

there are six osteopathic schools. Their last freshman admission class averaged less than 100 per school. There seems to be a total of slightly over 1900 registrants at the present time and the graduating class for the coming year will probably be slightly over 400. The ratio of osteopaths to doctors of medicine is estimated at the present time to be about 1 in 17 for the entire United States. In 1952, 34 states and the District of Columbia recognized graduates of these osteopathic schools as eligible to full license to practice medicine and surgery. Eight states grant licenses limiting the use of their practice to drugs but no major surgery. In 20 states osteopaths participate in voluntary health insurance programs. In 25 they may render care to injured workmen under industrial accident laws. Osteopaths may serve in the Veterans Administration. There is permissive legislation that would allow them to serve professionally in the Armed Forces of the United States and in the United States Public Health Service. So far as is known, none have been accepted in these latter categories.

The Liaison Committee on Medical Education is still obtaining reports from the respective county medical societies. Therefore, the committee may wish to make a supplementary report at the annual meeting since this report of the committee must be submitted before an evaluation of the questionnaires can be completed.

Respectfully submitted,

H. CLOSE HESSELTINE, M. D., *Chairman*. LEO P. A. SWEENEY, M. D., JACOB E. REISCH, M. D., *Liaison Committee on Medical Education*.

DR. H. CLOSE HESSELTINE: We have a supplementary report.

The Liaison Committee on Medical Education of the Council of the Illinois State Medical Society submits a supplementary report in the form of a resolution.

*Whereas*, the Board of Trustees and the House of Delegates of the American Medical Association last June referred to each state three questions to be answered by the component societies of the respective states; and

*Whereas*, the Council of the Illinois State Medical Society appointed a committee of three to obtain from and tabulate the answers from its component societies; and

*Whereas*, this committee sought to obtain additional information for the Illinois delegates to the convention of the American Medical Association as well as for the Illinois State Medical Society by adding a fourth question; and

*Whereas*, eighty-one component societies have replied to the four questions with the following majority opinions:

1. Should modern osteopathy be classified as "cultist" healing? *ANSWERED, YES*

2. Since the objectives of the A.M.A. include improvement of undergraduate and postgraduate education, should doctors of medicine teach in osteopathic schools? *ANSWERED, YES*

3. Should the relationship of doctors of medicine to

doctors of osteopathy be a matter for determination by the several state associations?

*ANSWERED, YES*

4. If the Council on Medical Education of the A.M.A. (or an agent or agency acceptable to it) approved one or more of the osteopathic schools as having educational standards comparable to class "A" medical schools and the graduates of these schools adhered to medical practices and ethics comparable to that of doctors of medicine would you classify these osteopaths as cultists?

*ANSWERED, NO*

*Therefore, be it resolved*, that these tabulations serve as the instructions for the delegates from the Illinois State Medical Society to the American Medical Association meeting in San Francisco in June, 1954.

Respectfully submitted,

H. CLOSE HESSELTINE, M. D., *Chairman*. LEO P. A. SWEENEY, JACOB E. REISCH, *Liaison Committee on Medical Education*.

THE PRESIDENT: This supplementary report will be referred to the Committee on Miscellaneous Business.

#### REPORT OF THE EDITORS ILLINOIS MEDICAL JOURNAL

Several changes, both in appearance and contents of the Illinois Medical Journal, were made in the past year. Members of the Journal Committee and the Editorial Board met several times to discuss Journal problems.

At each meeting, a number of papers submitted for publication were referred by the editors to the committee members for recommendations on the advisability of publishing them. It is our desire to publish papers on subjects of general interest to readers of the Journal. We have returned to the authors a number of papers with the recommendation that they be published in a specialty journal as they were highly technical and of interest chiefly to certain branches of medicine.

The editors, as well as the editorial board and journal committee, again ask that papers be shortened. Too often we receive papers 30 typewritten pages long. It is our constant desire to publish as many papers as possible in each issue of the Journal and, if they are relatively short, more authors can be represented. We would like to ask authors to take more care in preparing the first paragraphs and the summary. Many readers glance at the first two or three paragraphs and the summary before deciding to read the article in its entirety. Although we still have quite a number of papers that have been approved for publication, we always welcome papers on current medical subjects. It is our desire to have two case reports in each issue, and we are interested in receiving such articles regularly.

Your editors have been requested to give a short summary on the papers published in the Journal during the past fiscal year, and to state the number that were written by authors designated as specialists as well as the number written by authors not having such a designation. Between May, 1953 and April, 1954, 93

original articles were published. Some were written by two physicians, so that the totals do not necessarily correspond. Seventy authors are listed as specialists, while 31 do not have such designation. Some of these authors are young men not yet listed in our specialists' directory.

Beginning with the July 1953 issue, changes were made in the arrangement of the contents. We now start with scientific papers then go to pathologic conferences, editorials, medical economics, the P. R. page, correspondence, and news of the state. The P. R. page is a new department. This makeup, we believe, has met with the approval of many of our readers but we would appreciate further comments.

We have been asked repeatedly by some commercial firms to carry an advertisement on the lower half of the front cover, as is done in a number of state medical journals. Our Council, the Editorial Board, and the Journal Committee have not been willing to permit the carrying of any advertisements on the front cover and we believe this ruling will stand for future issues. We do not carry advertisements between scientific articles or at any place other than the front and back sections of the Journal.

We invite your comments on the red cover. As requested by the Council, as well as by the Journal Committee, we have used this color during the past year. We also want to call your attention to the new type of binding, similar to that used by many other medical journals including the Journal of the American Medical Association. This change was made starting with the January, 1954 issue. Next year we hope to make additional improvements in make up including paper and type.

For many years the July and August issues have carried the transactions of the meetings of the House of Delegates at the annual meeting. The minutes, as recorded by our official reporter, required so much space little room was left for scientific articles. Last year, upon the recommendation of the Editorial Board and the Journal Committee, and with the approval of the Council, abstracts of these transactions were published, thereby saving space for other material. This was done without losing actions and discussions taken in the House of Delegates meetings, and we would appreciate your comments on adopting a similar procedure for future issues. The American Medical Association has adopted this procedure in publishing transactions of its House of Delegates, and many states are doing the same. This action will help us to publish our backlog of fine scientific papers. With a reactivated Committee on Industrial Health, which has held many meetings during the past year, we have been urged to publish papers on various subjects in that field. They are being selected by the committee and we hope to carry them regularly. With the many problems in connection with the operation of the Illinois Workmen's Compensation Acts, all physicians in this state ought to be thoroughly aware of their duties in caring for

injured and sick workmen, for whose care the employers are responsible.

Your editors spend one day each week with Mr. L. E. Malley in our office at 185 North Wabash Avenue, Chicago. Mr. Malley, designated as business manager for the Illinois Medical Journal, has been acting in this capacity for more than 12 years. When new products are submitted for advertising in the Journal, Mr. Malley shows the copy to each member of the Journal Committee and is governed by its decision on whether or not the advertisement will be accepted. He deals with many advertising agencies and some companies individually, receives their copy, and cares for the monthly billings. He orders cuts used to illustrate scientific papers, makes up the dummy, and performs numerous other duties referred to him. Mr. Malley makes a monthly report to the treasurer, at which time he sends him all advertising receipts. We are fortunate in having a business manager who handles these duties so satisfactorily and who works with us so harmoniously. The Illinois Medical Journal is your Journal and we would greatly appreciate your suggestions as to ways it may be made more to your liking.

Respectfully submitted,

HAROLD M. CAMP, M. D., THEODORE R. VAN DELLEN, M. D., *Editors.*

#### COMMITTEE ON CONSTITUTION AND BY-LAWS

DR. WARREN W. FUREY, Chicago: You will note that there is no report from the Committee in the HANDBOOK. We had the feeling there would be no business for this Committee for the year until yesterday. Representatives of the A.M.A. came to see me at the suggestion of Dr. Camp with a resolution to induce interns and residents to become members of organized medicine. The A.M.A. regretfully states that there are 70,000 physicians in the United States who are not members of the A.M.A. Of these, 30,000 are serving as interns and residents. There is no provision in the constitution and by-laws for accepting them as members. I will present this resolution that was given to me.

#### A RESOLUTION TO INDUCE INTERNS AND RESIDENT PHYSICIANS TO BECOME MEMBERS OF ORGANIZED MEDICINE

*Whereas*, an average of 7,000 physicians graduate each year from approved medical schools in the United States and Canada, and

*Whereas*, there is an unusual length of time between the date a physician graduates and the date he begins the practice of medicine and becomes affiliated with a component and constituent medical society, and

*Whereas*, it would be of mutual benefit to organized medicine and to these new physicians to enable them to hold membership in their component and constituent societies, and the A.M.A., and

*Whereas*, many of these physicians have already expressed a desire to be affiliated with organized medicine but are prevented from so doing because the societies do not make provision in their Constitution and By-Laws for these groups of physicians, and the cost of

regular membership is such that they cannot meet the obligation, and

*Whereas*, many of these physicians are already licensed in one state but may not be licensed in the state in which they are serving their internship or residency, and

*Therefore be it resolved*, that this House of Delegates go on record as endorsing a type of membership for physicians who have been licensed to practice medicine in any one state and who are serving internships and residencies, and fellowships, within the first five years following graduation, with due allowance for time spent in military service, and

*Be it further resolved*, that only graduates of approved medical schools in the United States and Canada be accepted, and

*Be it further resolved*, that the component and constituent associations charge such members either no fee or a nominal fee, and

*Be it further resolved*, that an intern or resident physician may continue to hold membership in the component and constituent associations as long as he is serving an internship, residency, or fellowship even if he moves to a hospital in another state, and

*Be it further resolved*, that during any year that his hospital service or training ceases, the physician's membership will cease at the end of that year, and, if he wished to continue as a member of his component and constituent associations, he must apply for regular membership, and

*Be it further resolved*, that the Secretary of this Society be instructed to send a copy of this resolution to the Secretary of each component society in this state, to be read at the next regular meeting, and further request that this action be presented to the House of Delegates of the A.M.A.

In order to accomplish the purpose set forth in this resolution the Constitution and By-Laws Committee recommends the following amendments to the Constitution:

Amend Article IV, present Section 4, titled RESIDENCY MEMBERS by the following:

1. Delete the words "in the State of Illinois" on lines 4 and 5.
2. Add at the end of paragraph 1 the following: "A physician licensed in any state of the United States who is serving as a resident or fellow in an approved hospital in the State of Illinois may also enjoy the privilege of this type of membership".
3. Change \$5.00 per capita, line 1, paragraph 2, to \$2.00 per capita.
4. Add the following: "When his training ceases, the physician's RESIDENCY MEMBERSHIP will cease at the end of that year, and, if he wishes to become a member of the Society, he must apply for regular membership through his component society.
5. Add a new Section 4 titled: INTERN MEMBERS. Any person who is a graduate of a medical school, who is a citizen of the United States and who is of

good moral and professional standing and who is serving an internship in any hospital in the State of Illinois approved by the Council on Medical Education and Hospitals of the American Medical Association, is eligible for intern membership for a period of not more than two years after graduation on the recommendation of any two members of this Society who are also members of his Hospital Staff. When his training ceases the physician's intern membership shall cease at the end of that year, and, if he wishes to become a member of this Society he must apply for Residency or regular membership through his component society. Dues for intern membership shall be ..... minimal.

6. Amend Article IV by changing Sections 4, 5, 6, 7, and 8 to Sections 5, 6, 7, 8, and 9.

Then the ARTICLE IV — COMPOSITION OF THE SOCIETY — will read as follows:

Section 1 — same as printed on page 3.

Section 2 — same as printed on pages 3 and 4.

Section 3 — same as printed on page 4.

Section 4 — INTERN MEMBERS. Any person who is a graduate of a medical school, who is a citizen of the United States and who is of good moral and professional standing, and who is serving an internship in any hospital in the State of Illinois approved by the Council on Medical Education and Hospitals of the American Medical Association, is eligible for intern membership for a period of not more than two years after graduation on the recommendation of any two members of this Society who are also members of his Hospital Staff. When his training ceases the physician's intern membership shall cease at the end of that year, and, if he wishes to become a member of this Society he must apply for Residency or regular membership through his component society. Dues for intern membership shall be ..... minimal.

Section 5. RESIDENCY MEMBERS. After being licensed to practice medicine, a physician serving full time as a resident or fellow in an approved hospital, may enjoy all the privileges of full membership at a special rate up to five years after graduation in medicine, except that the time spent in military service may be excluded in calculating the five year limit. Thereafter the full rate shall apply. A physician licensed in any state of the United States who is serving as a resident or fellow in an approved hospital in the State of Illinois may also enjoy the privilege of this type of membership.

The special rate shall be \$2.00 per capita per annum. A residency must have a degree of Doctor of Medicine or its equivalent, must be a member in good standing of his component society and must be a citizen of the United States.

When his training ceases, the physician's Residency membership shall cease at the end of that year, and, if he wishes to become a member of this Society he must apply for regular membership through his component society.

Section 6 — (formerly Section 5) remains the same as printed on page 5.

Section 7 (formerly Section 6) remains the same as printed on page 5.

Section 8.— (formerly Section 7) remains the same as printed on page 5.

Section 9 — (formerly Section 8) remains the same as printed on page 5.

Respectfully submitted,

WARREN W. FUREY, M. D., *Chairman*; PLINY R. BLODGETT, M. D., A. F. GOODYEAR, M. D., JACOB E. REISCH, M. D.

DR. EDWARD WELD, Rockford: May I ask a question? It states there that in order to be eligible for junior membership he has to be a citizen of the United States. Is that correct?

DR. FUREY: Yes.

THE PRESIDENT: This will be referred to Reference Committee "C".

The Secretary has no unfinished business, so we will pass to new business.

DR. A. M. VAUGHN, Chicago: I was at the American Goiter Society meeting last week and they had a distinguished guest from England, Dr. Tobey Levitt of London, Hunterian Professor of the Royal College of Surgeons. He is here today and I would like to introduce him.

DR. LEVITT: This is a totally unexpected pleasure and distinction to be presented to people many of whose names I have known and read about in the literature. I do look upon it as a great distinction to meet you personally when the occasion arises.

THE PRESIDENT: We are very glad to have you with us, Dr. Levitt.

We now come to the introduction of resolutions. I recognize Dr. Blodgett.

DR. PLINY R. BLODGETT, Chicago Heights: I have three resolutions.

1. *RESOLUTION ON HR-6949 and HR-8356-S-3114*

*Whereas*, Congressman Charles A. Wolverton on January 6, 1954 introduced HR-6949 which would establish a federal corporation to reinsure the voluntary non-profit health plans, and

*Whereas*, Congressman Charles A. Wolverton and Senator Alexander Smith introduced on March 11, 1954 HR-8356 and S-3114 (identical bills) which would establish a federal corporation to reinsure virtually every type of health plan, providing it is based on prepayment, and

*Whereas*, federal reinsurance would be a form of federal subsidization of the health plans, and

*Whereas*, subsidization by any agent of government inevitably leads to control by government and to rapidly deteriorating performance of functions so subsidized, and

*Whereas*, subsidy proposals represent merely an intermediate step by the socializers toward their ultimate goal of complete government domination, and

*Whereas*, federal subsidy and control would materially weaken the voluntary plans by encouraging actuarially unsound insurance practices and thus make them a

vehicle for complete socialization of medical care, and

*Whereas*, the voluntary plans of prepayment insurance have been enjoying a natural and healthy growth thus making it possible for more and more of the citizens to distribute the costs of their medical care through sound, actuarial insurance experience, and

*Whereas*, financial assistance to the voluntary plans—either through federal reinsurance or federal subsidy—is not and should never be the responsibility of a centralized federal government, and

*Whereas*, financing of the provisions of the various proposals for subsidization of the voluntary prepayment insurance plans would require millions of dollars which would have to be supplied through taxes from citizens already impoverished by existing needless and excessive taxation, and

*Whereas*, federal financial assistance to the insurance plans would be an unfair and immoral act because it would constitute unfair competition to the insurance plans which refuse the federal aid.

*Therefore, be it resolved*, that the members of the Illinois State Medical Society in regular session assembled this 21st day of May, 1954, oppose the passage of HR-6949 and HR-8356 -S-3114 and all similar legislation which proposes federal reinsurance or direct federal subsidization of the voluntary and private health plans.

## 2. *RESOLUTION OPPOSING THE EXPANSION OF SOCIAL SECURITY AND THE INCLUSION OF PHYSICIANS IN THE SOCIAL SECURITY SYSTEM*

*Whereas*, Congressman Carl T. Curtis has introduced Social Security bill HR-6863 and Congressman Daniel A. Reed has introduced Social Security bill HR-7199 which would extend Social Security coverage to an additional 10,500,000 persons, of which 6,500,000 persons, including physicians, would be compelled to join the system, and

*Whereas*, there is growing sentiment throughout the nation that the Social Security program is basically wrong and actuarially unsound and should be repealed, and

*Whereas*, the Social Security System is based on a complete compulsory principle that is contrary to the essential principles of individual liberty and Freedom.

*Therefore, be it resolved* that the members of the Illinois State Medical Society in regular session assembled this 21st day of May, 1954 do hereby go on record as being unequivocally opposed to HR-6863 and HR-7199.

## 3. *RESOLUTION SUPPORTING ACTION TO DETERMINE THE POSITION OF ALL CANDIDATES ON THE BRICKER AMENDMENT AND THE PROPOSED 23RD AMENDMENT*

*Whereas*, certain threats to our free economy and to our Constitutional Government are daily becoming more apparent, and

*Whereas*, these threats make it more essential than

ever that we know the position of candidates for public office on certain basic issues.

*Therefore, be it resolved* that the members of the Illinois State Medical Society in regular session assembled this 21st day of May, 1954 urge every member of the Society to enlist the support and assistance of local organizations in determining the stand of all candidates for state or national office on the two great basic issues of our time: (1) The Bricker Amendment (S. R. Res. 1) and (2) the Proposed 23rd Amendment (H. T. Res. 123) which provides "The government of the United States shall not engage in any business, professional, commercial, financial or industrial enterprise except as specified in the Constitution."

THE PRESIDENT: The three resolutions will be referred to the Committee on Miscellaneous Business.

I recognize Dr. Percy E. Hopkins.

DR. PERCY E. HOPKINS, Chicago: I wish to present the following resolution:

4. *ENDORSEMENT OF CANDIDACY OF DR. EDWIN S. HAMILTON FOR PRESIDENT-ELECT OF THE AMERICAN MEDICAL ASSOCIATION*

*Whereas*, Edwin S. Hamilton, M.D., a member of the Kankakee County Medical Society, and a member of the Illinois State Medical Society has consented to be a candidate for the high office of president-elect of the American Medical Association in June, 1954, and

*Whereas*, Edwin S. Hamilton, M.D. has for many long years actively cooperated with and been active in the work of the Illinois State Medical Society and the American Medical Association as well as in other organizations in attempting to improve the welfare of the people and of organized medicine, and

*Whereas*, Edwin S. Hamilton, M.D. has eminently and repeatedly demonstrated his fitness and qualifications for the high office of president-elect of the American Medical Association.

*Therefore be it resolved*, that the House of Delegates of the Illinois State Medical Society endorse said candidacy of Dr. Hamilton and put forth every effort to further the candidacy of Dr. Hamilton for the office of president-elect of the American Medical Association.

DR. HOPKINS: I would like to move that the House of Delegates resolve itself into a committee of the whole to consider this resolution at this time. (Motion seconded by Dr. W. E. Kittler, Rochelle.).

THE PRESIDENT: I will rule that it needs no reference. Those in favor of its being referred to a committee of the whole, signify by the usual sign. (Motion carried).

DR. HOPKINS: I would move the adoption of this resolution. (Motion seconded by Drs. Pliny Blodgett, Chicago Heights, C. Paul White, Kewanee, and others, and carried).

THE PRESIDENT: The resolution is adopted unanimously. I recognize Dr. H. J. Nebel of East St. Louis.

DR. NEBEL: I would like to have the Attendance

Committee come forward and pass out copies of the proposed resolutions.

5. *FOREIGN TRAINED PHYSICIANS IN-ELIGIBLE FOR LICENSURE IN THE UNITED STATES*

*Whereas*, it is the present policy of the United States Government to admit into this country several hundred thousand of displaced persons from all over the world and from many areas that have not had an immigration quota and included are a large number of foreign trained physicians about whose ability little is known; and

*Whereas*, most foreign medical schools have not provided and currently cannot provide the pattern of medical education that is regarded everywhere in this country as minimal and foreign graduates in most instances have had no real training in the basic sciences or the clinical instruction so necessary in our concept of the proper training of the physician; and

*Whereas*, if large numbers of these foreign trained physicians without proper basic professional education enter into the practice of medicine in the United States it inevitably will lower the level of medical practice in this country for the next several decades; and

*Whereas*, the United States, for its own welfare must maintain the highest quality of medical practice in all its phases in order to provide the American people with what they now have, medical care not excelled anywhere in the world, therefore be it

*Resolved*, that the Illinois State Medical Society instruct its delegates to the American Medical Association to introduce and press for adoption a resolution directing the Council on Medical Education and Hospitals of the A.M.A. to withhold approval of any institution that accepts for intern or resident training foreign trained physicians who are ineligible for licensure in the United States, except those bona fide foreign graduates selected for training in this country and who return at the termination of said training.

6. *SCREENING OF FOREIGN TRAINED PHYSICIANS BY THE NATIONAL BOARD OF MEDICAL EXAMINERS AS A PRE-REQUISITE TO CONSIDERATION FOR LICENSURE*

*Whereas*, each state in this country has its own licensing board with its individual licensing privileges there is no common denominator that will give a true comparative evaluation of the basic science background and professional competence of foreign trained physicians for licensure; and

*Whereas*, the Councils of Medical Education and Hospitals of the A.M.A. and the Association of American Medical Colleges list as acceptable for approval but a few of the over 500 foreign medical schools of the world and find that a conscientious evaluation of medical schools on a world-wide basis presents difficulties that are practically insurmountable; and

*Whereas*, a uniform procedure for screening the basic knowledge and professional competence of foreign

trained physicians individually, completely disassociated from licensing privileges, will render a far greater service to the State Medical Licensing Boards than the combined efforts of the Councils can render through attempts to evaluate foreign medical schools; and

*Whereas*, the National Board of Medical Examiners being set up to conduct high quality examinations in keeping with the current advances of medicine present a highly effective and uniform screening device, therefore be it

*Resolved*, that the Illinois State Medical Society recommend to the Board of Registration and Education of the State of Illinois, that a mutually satisfactory method of procedure be developed with the National Board of Medical Examiners for the purpose of screening all foreign trained physicians, and be it further

*Resolved*, that the Illinois State Medical Society recommend to the Board of Medical Examiners that foreign trained physicians present evidence of having satisfactorily completed the National Board Examinations as a pre-requisite to consideration for licensure.

THE PRESIDENT: These resolutions will be referred to the Committee on Reports of Standing Committees, Dr. C. Paul White, Chairman.

I recognize Dr. Scatliff.

DR. H. KENNETH SCATLIFF, Chicago: I have a resolution from the North Shore Branch, which is printed on Page 202 of the HANDBOOK.

7. ALLOCATION OF FUNDS TO AMERICAN MEDICAL EDUCATION FOUNDATION BY ORGANIZATIONS COLLECTING MONIES FROM THE PUBLIC FOR MEDICAL EDUCATION

NORTH SHORE BRANCH  
CHICAGO MEDICAL SOCIETY

*Whereas*, the basis of good medical care is the well trained general physician whose training requires medical educational institutions well equipped with modern laboratories and not restricted to one field of research, and

*Whereas*, the medical schools of the nation are in dire need of general funds, not especially earmarked, to maintain their educational and research programs, and

*Whereas*, the medical profession has set up in the American Medical Education Foundation a means by which financial aid to medical schools can be furnished equitably, and

*Whereas*, there are many organizations that solicit and collect large sums of money from the public for purposes of research, education and improvement of the medical care in specific fields of medicine, and

*Whereas*, such organizations require and have received the good will and cooperation of the medical profession, in the past.

*Therefore be it resolved*, that organizations which solicit and collect moneys from the public for the advancement of medical knowledge and medical care in specific fields be urged to allocate a proportion of their funds to the American Medical Education Foundation

for the general program of the schools, and be it further

*Resolved*, that the attention of the American Medical Association be directed to this matter through the usual channels with a view to implementation of the same.

Respectfully submitted,

NORTH SHORE BRANCH,

CHICAGO MEDICAL SOCIETY

*Initiated by Executive Committee, North Shore Branch, April 27, 1954.*

*Approved by Chicago Medical Society, May 3, 1954.*

*Approved by North Shore Branch May 4, 1954.*

THE PRESIDENT: This resolution will be referred to the Committee on Reports of Standing Committees, Dr. C. Paul White, Chairman.

I recognize Dr. Hoeltgen.

DR. M. M. HOELTGEN, Chicago: I have a resolution from the Chicago Medical Society.

8. AMENDMENTS TO STANDARDS FOR HOSPITAL ACCREDITATION

*Whereas*, the Standards for Hospital Accreditation, promulgated by the Joint Commission on Accreditation of Hospitals empower the governing body (Article 1,B) to appoint members of the medical staff, upon recommendation for the active staff (Article II, A3a); and

*Whereas*, the "governing body" is in the majority of instances composed of lay persons of diversified vocations and occupations, totally unrelated to any branch of medicine and possessing no medical training; and

*Whereas*, this polyglot group of laymen, sitting as a governing body, has no code of ethics comparable to that of the American Medical Association that remotely qualifies them to pass judgment, without recourse, on any member of the medical staff of hospitals; and

*Whereas*, the governing body, without announcing any reason whatsoever or based merely on the whim or caprice of any of its members, may refuse to approve an appointment or reappointment recommended by the active staff; and

*Whereas*, the career of a staff member may be ended or seriously suffer by his failure to secure a recommended reappointment and it is equitable that he be judged by his peers on the active staff; and

*Whereas*, the recommendations of the active staff, which is charged with the quality of medical care and the maintenance of ethical standards (Article II, A1), should be concurred in; and

*Whereas*, it is necessary to amend the above Standards to effectuate the purposes of this resolution; now, therefore

*Be it resolved*, that the South Chicago Branch of the Chicago Medical Society approves the following amendments (proposed) to the Standards for Hospital Accreditation of the Joint Commission on Accreditation of Hospitals, namely,

1. Add to Article I, B1, after "requirements" the following: "and these Standards."

2. Insert in Article II, A3a, in the third line thereof,

after the word "appointment" the following: "and re-appointment."

3. Add to Article II, A3a, the following: "If the governing body refuses to approve any recommended appointment or reappointment, it shall transmit its reasons in writing therefor to the active staff."

*Be it further resolved*, that this resolution be presented to the Chicago Medical Society for their consideration and, upon approval, be presented to the Illinois State Medical Society for approval and further presentation to the House of Delegates of the American Medical Association, with a request for early presentation by the representatives of the American Medical Association on the Joint Commission on Accreditation of Hospital, for inclusion of the above amendments to the Standards for Hospital Accreditation.

This resolution was presented from the South Chicago Branch and adopted by the Council of the Chicago Medical Society at its meeting on April 13, 1954.

THE PRESIDENT: This will be referred to the Committee on Reports of Standing Committees, Dr. C. Paul White, Chairman. I recognize Dr. Harold W. Miller.

DR. HAROLD W. MILLER, Chicago: I have a resolution from the Association of American Physicians and Surgeons.

9. RESOLUTION TO APPROVE SPONSORSHIP OF THE 1955 ASSOCIATION OF AMERICAN PHYSICIANS AND SURGEONS ESSAY CONTEST

*Whereas*, the Association of American Physicians and Surgeons has sponsored eight successive annual national Essay Contests for high school students, and

*Whereas*, A.A.P.S. is sponsoring its ninth successive Contest, known as the 1955 A.A.P.S. Essay Contest, on the new subject: "The Advantages of Private Medical Care," and

*Whereas*, the Purdue University Opinion Poll reveals that approximately 55 per cent of the nation's high school students approve of socialized medicine, and

*Whereas*, the issues of private practice versus socialized medicine and Human Freedom versus Socialism require a spirited fight for the impressionable young minds of the nation's youth, and

*Whereas*, there is a continuing need for educational programs like the Essay Contest because each year a new group of high school students must be enlightened, and

*Whereas*, the A.A.P.S. Essay Contest has proved to be a most effective medium to educate youth away from Socialism.

*Therefore, be it resolved*, that the Illinois State Medical Society sponsors the 1955 Contest and that all Illinois County Medical Societies be urged to sponsor the Contest at their respective county levels.

THE PRESIDENT: This resolution will be referred to Committee on Reports of Council Committees "D", Dr. George B. Callahan, Chairman.

I recognize Dr. Walter Whitaker.

DR. WALTER WHITAKER, Quincy. I wish to

present the resolution from Adams County which appears on Page 200 of the HANDBOOK.

10. REQUEST TO ABANDON SCIENTIFIC SESSIONS AND EXHIBITS AT THE ANNUAL INTERIM MEETING OF THE A.M.A. IF NOT TO ABANDON THE ENTIRE MEETING

December 18, 1953

ADAMS COUNTY

*Whereas*, with the great increase in the number of medical organizations in recent years together with the great increase in the number of hospitals and the organization of practically all hospital medical staffs, physicians in general are called upon to attend an excessive number of medical and hospital meetings, and

*Whereas*, with the comparatively recent organization of the American Academy of General Practice, especially appealing to general practitioners, with a large annual meeting, together with annual meetings of chapters in nearly every state together with more frequent meetings of county or district units of that organization, and

*Whereas*, with the rapid growth of the International College of Surgeons, especially appealing to general surgeons, most of whom do general practice, and with its largely attended annual meeting, and

*Whereas*, the American Medical Association began in 1948 to hold an interim or clinical session each year in December, especially appealing to physicians in general practice, making another annual meeting for general practitioners to attend, and

*Whereas*, there have been organized within the past few decades numerous regional medical organizations (not to mention the scores of specialty organizations) appealing to general practitioners, such as the Mississippi Valley Medical Society, Kansas City and Southwest Clinical Society, Chicago Medical Society Clinical Conference, Omaha Clinical Conference, and scores of others, be it

*Resolved* that the delegate of the Adams County Medical Society be requested to present to the House of Delegates of the Illinois State Medical Society a resolution requesting the delegates of the Illinois State Medical Society to the American Medical Association Meeting, next June, do everything in their power to urge the House of Delegates of the American Medical Association to abandon scientific sessions and exhibits at the annual interim meeting of the A. M. A. each December, if not to abandon the entire meeting, and thus help relieve the excess of medical meetings physicians in general practice are called upon to attend.

THE PRESIDENT: This will be referred to Reference Committee "A", Dr. John R. Wolff, Chairman. Dr. Weld is recognized.

DR. EDWARD A. WELD, Rockford: I wish to present the following resolution.

11. DISCONTINUANCE OF COMPULSORY ASSESSMENT FOR THE AMERICAN MEDICAL EDUCATION FOUNDATION

*Whereas*, for the past three years we have been

compelled to contribute to the American Medical Educational Foundation,

*Whereas*, the contribution is compulsory,

*Whereas*, two resolutions were passed by this House of Delegates in 1953 urging every state to adopt The Illinois Plan and urging delegates and our trustees in The American Medical Association to use every effort to get every state to adopt The Illinois Plan,

*Whereas*, up to date only two other states, with comparatively few physicians, have adopted The Illinois Plan. (Utah has 573 members in their association and Arizona has 654 members of their association or a total of 1,227 who will contribute next year. Illinois has 9,748 members who have been contributing for the past three years). (These figures are based on a 1949 census).

*Whereas*, state owned and operated and financed medical schools benefit by the plan,

*Whereas*, we are now paying into this fund through The American Medical Association and The Women's Auxiliary,

*Therefore, be it then resolved* by the House of Delegates of the Illinois State Medical Society that they discontinue their compulsory assessment from now on.

This resolution was unanimously adopted at the May 14, 1954 meeting of the Winnebago County Medical Society assembled in regular session at the LaFayette Hotel in Rockford, Illinois.

THE PRESIDENT: Thank you Dr. Weld. This will be referred to the Committee on Reports of Standing Committees, Dr. C. Paul White, Chairman. Dr. Petrazio is recognized. This resolution is printed on Page 201 of the HANDBOOK.

DR. J. A. PETRAZIO, Ava: This resolution was adopted by the Jackson County Medical Society, January 26, 1954.

#### 12. REQUIREMENT OF CITIZENSHIP FOR LICENSE TO PRACTICE MEDICINE IN ILLINOIS

##### JACKSON COUNTY

*Whereas*, the members of the Medical Society of the County of Jackson in the State of Illinois have met and discussed the advisability of legislation requiring that all physicians and surgeons practicing in the State of Illinois be citizens of the United States, and

*Whereas*, the members of said society deem it to be to the best interests of the local, state societies and the American Medical Association and to the public generally that licensed physicians and surgeons be citizens of the United States, and

*Whereas*, certain abuses and practices have arisen as a result of licensing to practice medicine in this state certain physicians not citizens of the United States;

*Now Therefore Be It Resolved* by the Jackson County Medical Society in regular meeting assembled this 26th day of January, 1954, that said society and all members thereof favor and are on record for the enactment of legislation by the General Assembly of the State of Illinois providing that no license to practice medicine in the State of Illinois should be issued to

anyone who is not a citizen of the United States.

Adopted the 26th day of January, 1954.

Andrew R. Esposito, M. D., *President*.

ATTEST: Edw. K. Ellis, M. D., *Secretary*.

THE PRESIDENT: This resolution will be referred to Committee on Reports of Standing Committees, Dr. C. Paul White, Chairman.

I recognize Dr. Walter Baer of Peoria.

DR. WALTER H. BAER, Peoria: I have two resolutions to present.

#### 13. APPOINTMENT OF COMPETENT MENTAL HOSPITAL ADMINISTRATORS TO HEAD ILLINOIS STATE HOSPITALS AND SCHOOLS

*Whereas*, the Dixon State School, an institution, under the supervision of the Illinois Department of Public Welfare, where 5,268 post-encephalitic, epileptic and mentally deficient persons are hospitalized, and

*Whereas*, the chief administrative officer of this institution has heretofore always been a medically trained administrator in accordance with well established medical policy, and

*Whereas*, recently the medical administrator has been replaced with a lay administrator, now

*Therefore be it resolved*, that the Illinois State Medical Society voice its disapproval of this departure from sound medical administration and ask the Governor of Illinois to reconsider the action taken and establish a policy of appointing competent Mental Hospital Administrators to head the Illinois State Hospitals and Schools.

#### 14. REFORMS IN ADMINISTRATION OF STATE HOSPITALS

*Whereas*, the Illinois State Mental Hospitals, under the supervision of the Illinois Department of Public Welfare, are responsible for the care and treatment of over 47,000 hospitalized patients, and

*Whereas*, not a single one of the major State institutions has met the minimum standards for approval by the American Psychiatric Association and the Joint Accreditation Commission, and

*Whereas*, the present overcrowding and understaffing, and sub-standard level of medical care given deprives many patients of the chance to recover from their illness, and

*Whereas*, the Illinois State Medical Society has an obligation to see to it that the patients in these institutions receive modern treatment, now

*Therefore, be it resolved*, that the Illinois State Medical Society take effective action to bring about urgently needed reforms in the administration of these hospitals and improve the character of medical care and treatment to at least minimal levels of acceptable standards.

THE PRESIDENT: These two resolutions will be referred to Committee "E", Dr. Warren W. Furey, Chairman.

Dr. Joseph T. O'Neill is recognized.

DR. JOSEPH T. O'NEILL, Ottawa:

#### 15. SCHOOLS OF NURSING

*Whereas*, it has come to the attention of the Council

of the Illinois State Medical Society through reports of its Councilors and in the report of the Committee on Nursing as published in the HANDBOOK of official reports that the small schools of nursing in Illinois are in jeopardy, and

*Whereas*, the report of the Committee on Nursing shows that there were 80 approved schools of nursing in Illinois in 1953 and only 78 approved schools in 1954, and

*Whereas*, the shortage of registered nurses particularly in the rural areas will become extremely acute if this trend continues, and

*Whereas*, the employment of practical nurses and nurses aides in the smaller rural hospitals will not adequately compensate for the numerical loss in registered nurses if the trend continues to close the small schools of nursing,

*Therefore be it resolved*, that the House of Delegates of the Illinois State Medical Society is extremely perturbed about the schools of nursing in the State of Illinois, particularly in the rural areas, and while the House of Delegates wishes to encourage the enrollment in schools of practical nursing and wishes to aid in the establishment of additional schools, it strongly urges that everything possible be done to keep our present hospital schools of nursing, and that we exhaust every means to obtain more hospital schools of nursing and to

encourage and to increase the enrollment in these schools, and

*Be it further resolved*, that a copy of this resolution be sent to the Governor, the Honorable William G. Stratton, and to the Superintendent of the Department of Registration and Education, the Honorable Vera Binks, and

*Be it further resolved*, that a suitable resolution expressing these principles be prepared and presented to the House of Delegates of the American Medical Association urging their favorable consideration of these recommendations.

THE PRESIDENT: This will be referred to Committee "E".

If there are no other resolutions, is there other business to come before the House?

THE SECRETARY: I have no other new business.

THE PRESIDENT: I would like to ask the Chairman of each Reference Committee to please get the folder, have your Committee stand to make sure your members are all present.

I will now entertain a motion for adjournment.

DR. LEO P. A. SWEENEY, Chicago. I move that we adjourn until 3:00 P.M. Thursday. (Motion seconded by Dr. Mather Pfeifferberger, Alton, and carried).

The House adjourned at 11 o'clock, to reconvene on Thursday at 3 P.M.

**The minutes of the second and third sessions of the House of Delegates  
will appear in the August issue**

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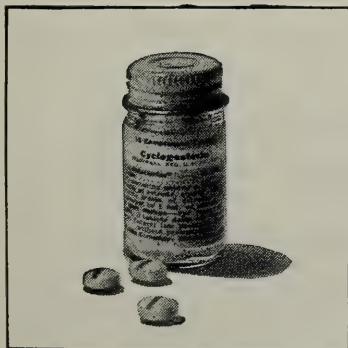
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## BOOK REVIEWS



STEDMAN'S MEDICAL DICTIONARY. Williams & Wilkins Company, Baltimore, 1953. 18th edition. \$11.50.

The new edition includes several thousand additional words and 600 illustrations. This supplementary material has increased the bulk of the dictionary so that it now compares in size with the larger textbooks. The illustrations are excellent and the definitions, clear and concise. The type is clear. There are more than 1,500 pages of definitions, preceded by an extensive medical etymology. The appendix offers numerous charts on weights, measures, temperature scales, chemical elements, and new nomenclature. This dictionary is highly recommended.

T. V. D.

TEXT BOOK OF PHYSIOLOGY AND BIO-CHEMISTRY by George H. Bell, Professor of Physiology, University of St. Andrews, University College, Dundee and J. Norman Davidson, Gardinier, Professor of Physiological Chemistry, University of Glasgow, and Harold Scarborough, Professor of Medicine, Welsh National School of Medicine, University of Wales. Second Edition. 1002 pages, profusely illustrated. E. & S. Livingstone Ltd., Edinburgh and London. (Printed in Great Britain.) The Williams & Wilkins Co., Baltimore, Md. \$10.00.

This is the second edition of this work. The

first edition appeared in 1950 and was reprinted in 1952.

This volume is as its title states, a text book for medical students. However, because of the approach to the many and varied aspects of the human body as to its many functions, this text book presents very many ideas and facts that are practical for the practicing physician. Whether general practitioner, surgeon or the "most specialized" specialist, the considerations herein are quite necessary to the full knowledge of perfection in the restoration of the "sick" functions of the patient's body. These authors bring to this one book an advantage from experience gained from very different fields. To secure today a complete and balanced picture of even the elements of physiology is doubtful of accomplishment by any one author. "Collaboration is essential." The combination of a physiologist, a biochemist and a clinician, insures the presentation of knowledge in this subject in a most practical manner. Mastery of the contents of this volume "lays a sure foundation for the medical student."

These three authors have endeavored to present their two subjects as one because they are so closely interwoven. And whenever possible these inter-relationships are not only demonstrated but their relevance to clinical problems is indicated. "Collaboration is essential" and

(Continued on page 36)

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## BOOK REVIEWS (Continued)

this work exemplifies this axiom. The result is superb from many views and especially from a teaching point of view.

The volume contains six chapters. The references are listed at the close of each chapter. This greatly facilitates its use and study.

This B. D. S. Text Book is a quite worth while publication. Especially, teachers and students of medicine should not overlook its use.

C. P. B.

### PEDIATRIC PROBLEMS IN CLINICAL PRACTICE.

H. Michal-Smith, Editor. Grune & Stratton, Inc., New York, 1954. \$5.50.

This book devotes 12 of its 13 chapters to a detailed description of a dozen types of handicaps in children. Each chapter is written by an expert in his field. Winthrop Phelps writes on cerebral palsy and William G. Lennox on epilepsy. The book begins with a discussion of the normal child by Arnold S. Gesell and includes concepts of growth, the cycles of behavior, maturity traits, and the appraisal of normality. Subsequent chapters are on the

sick child, the emotionally disturbed, the mental-sick, the orthopedically handicapped, the allergic, the cardiac, diabetic, epileptic, and the ly retarded, the brain injured, the cerebral pal-tuberculosis child.

The editor is Chief Clinical Psychologist at Flower and Fifth Avenue Hospital and his book will be maximum value to the general practitioner who lives closest to his patients and who is always in need of information on special pediatric problems. At the end of the book is a suggested list of reading material for parents on the various subjects covered.

T. V. D.

DISEASES OF THE LIVER by Michael A Spellberg, M. D. Grune & Stratton, Inc. New York, 1954. \$16.50

Dr. Spellberg, Associate Professor of Medicine, University of Illinois, has prepared a monumental volume on one of the most puzzling organs of the body. He has assembled a massive amount of knowledge and gives a bibliography of ap-

(Continued on page 40)

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## BOOK REVIEWS (Continued)

proximately 2,400 references. This is the definitive book on various aspects of hepatic disease and the reaction of the liver to a multitude of diseases and disorders. The 12 chapters are well organized and include significant tests of hepatic function, differential diagnosis, and therapy. Each is followed by a brief summary of the salient features, printed in boldface type.

T. V. D.

## BOOKS RECEIVED

The following books have been received for reviewing, and are herewith acknowledge. This listing should be considered as a sufficient return for the courtesy of the sender. Books that appear to be of unusual interest will be reviewed as space permits each month. Readers desiring additional information relative to books listed, may write the Editor who will gladly furnish same promptly.

**ATLAS OF ORTHOPEDIC TRACTION PROCEDURES.** By Carlo Scuderi, B. S., B. D., M. S., Ph. D., Clinical Associate Professor of Surgery, University of Illinois; Professor of Surgery, Cook County Graduate School. 124 illustrations. The C. V. Mosby Company, St. Louis, 1954. \$12.50.

**THE EMOTIONAL PROBLEMS OF CHILDREN — A Guide for Parents.** By Harry Joseph, M. D., Director, The Guidance Center of New Rochelle, Inc. and Gordon Zern. Crown Publishers, Inc., New York. \$3.75.

**A MANUAL OF OTOTOLOGY, RHINOLOGY AND LARYNGOLOGY.** By Howard Charles Ballenger, M. D., F. A. C. S. Professor of Otolaryngology, Emeritus, and recently Chairman of the Department of Otolaryngology, Northwestern University Medical School, and John J. Ballenger, B. S., M. S., M. D., Associate, Department of Otolaryngology, Northwestern University Medical School, Chicago. Fourth Edition. 365 pages. 136 illustrations and 3 plates in color. Lea & Febiger, Philadelphia. \$6.00.

**SEVENTY-FIVE YEARS OF MEDICAL PROGRESS 1878-1953.** Edited and with a foreword by Louis H. Bauer, M. D., F. A. C. P., Secretary-General, The World Medical Association; Past President, The American Medical Association. Lea & Febiger, Philadelphia, 1954. \$4.00.

**DOCTOR DAN, Pioneer in American Surgery — the inspiring story of Daniel Hale Williams, the Negro who was the first surgeon ever to operate successfully on the human heart.** By Helen Buckler. Little, Brown & Company, 34 Beacon Street, Boston 6. \$5.00.

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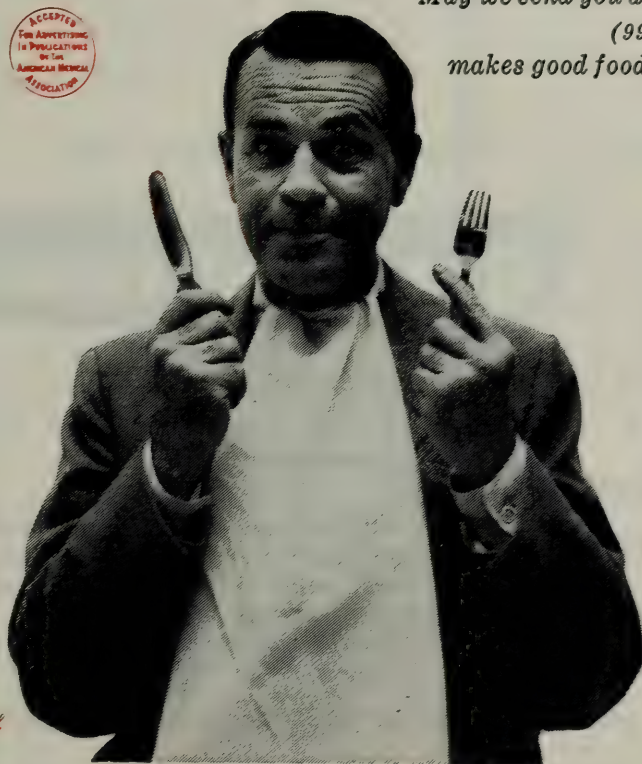
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If there is an important medical indication, either cortisone or ACTH may be given to the pregnant patient with caution but without apprehension. A growing literature on experimental animals indicates that large amounts of cortisone, given early in pregnancy, may cause fetal anomalies and/or miscarriages. Therefore, it may be well to avoid large doses of ACTH or cortisone in early pregnancy. However, there are now a number of cases in the literature in which moderate doses of these drugs have been given to women early in pregnancy with no untoward effects. Margulis and Hodgkinson report some questionable evidence of depressed adrenal function in a baby delivered of a mother who has received large doses of cortisone at term. Although the baby survived, it may be well to bear this possibility in mind and to discontinue or decrease cortisone therapy at term to allow the fetal adrenal to escape the suppressive mechanism of cortisone. Another factor to be considered in the administration of cortisone or ACTH to the pregnant patient at term, is the

poor wound healing that occurs following either type of therapy. This would pose an additional hazard to the post-operative course of the patient if cesarean section were necessary. Since wound disruption is more common after cesarean section than after other types of abdominal procedures, this is of particular significance. *Georgeanna Seegar Jones, M.D., and John Eager Howard, M.D., The Use Of ACTH And Cortisone Therapy In Obstetrics and Gynecology. New York J. Med. Nov. 1, 1953.*

It has been found that in pulmonary tuberculosis treated effectively with drugs for adequate periods there is little remaining reversible disease (lobular pneumonitis and tubercles without necrosis), and that the principal remaining components are necrotic nodules and fibrosis. The necrotic nodules frequently contain large numbers of tubercle bacilli, and usually communicate with bronchi or bronchioles, thus furnishing the anatomic prerequisites for potential relapse and dissemination. William B. Tucker, M.D., *Annals of Int. Med.*, Nov., 1953.

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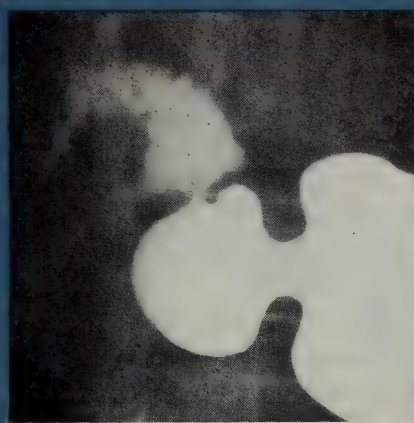
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1. HUFFORD, A. R.: MICH. STATE MED. SOC. 49:1308, 1950.

2. MCHARDY, G. AND BROWNE, D.: SOU. MED. J. 45:1139, 1952.

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There is little question in the minds of the authors that quinacrine hydrochloride is the most effective agent available at present for treatment of chronic discoid lupus erythematosus. The mechanism of action is unknown although it may be connected with the affinity of quinacrine for keratinous structures. In the present series, the side effects of treatment were not serious. Some patients complained of nausea and diarrhea, which may be alleviated by taking the drug with sodium bicarbonate after meals. The pigmentation is definitely disfiguring but this is only of cosmetic importance and it vanishes a few weeks after cessation of treatment. More serious complications — hepatitis, aplastic anemia, psychoses, and cutaneous eruptions — occurred during World War II when quinacrine was used to suppress malaria in the Pacific command. However, the incidence varied between 1 to 1,000 and 1 to 2,000 in persons taking quinacrine, and in practically all cases the complication occurred after several months of daily

ingestion of the drug. Bernard L. Rhodes, M.D., and Manuel F. Allende, M.D., *Treatment of Chronic Discoid Lupus Erythematosus with Quinacrine. California Med., Feb. 1954.*

## HEALTH CENTERS

Significant advances in the development of health centers in Latin America have been made since the inauguration of the co-operative health programs of the Institute of Inter-American Affairs and Latin American countries in 1942. The physician, the nurse, the statistician, the health educator, the social worker, the nutritionist, and the laboratory technician have all made contributions. The health center idea has been so convincingly demonstrated that Latin American health administrators have almost unanimously accepted it. Latin Americans attending schools of public health both in their own countries and in the United States have been exposed to it, and upon their assignment or reassignment to action programs, they usually have become apostles of the concept. *Growth of the Health Center Idea. Pub. Health Rep. Feb. 1954.*

## "A program of treatment for *chronic ulcerative colitis*...

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1. Rev. Gastroenterology 20:744 (Oct.) 1953; abstract in J. A. M. A., 153:1580 (Dec. 26) 1953.

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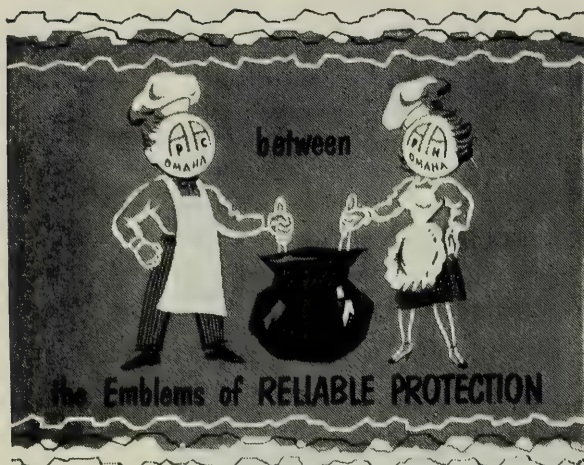
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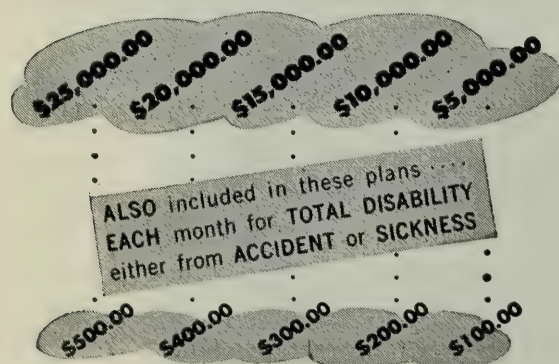
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## PARTNERSHIP PRACTICE

A problem exists in many cases where doctors have associated themselves in the practice of medicine. The basis on which they work may be a partnership, it may be an employer-employee relationship or it may be simply a completely informal relationship to save expense and duplication of equipment.

Very many times, the men involved consist of a well established elder doctor, who is beginning to look toward retirement, and a young man whose future is ahead of him. The elder man wants a way to pass on to his family, should he die, as much as possible of the value of his practice, and the younger man wants to know he is establishing his reputation in a spot where he will continue to work, and that he will not have to start over in some new area.

It is exactly the problem found in any business, with this exception: Only a small portion of a doctor's value is in the form of tangible property. Much of it is in the form of good will—years of faithful, expert service. This good will is reflected, to a large extent, in the habit which patients have of going to a certain office, where they have known satisfaction. (The sale of medical practices illustrates this point.) This good will should and can be preserved for his successor.

One good plan to accomplish this is to have a buy and sell agreement with an associate, so that at his death there is a ready purchaser at an agreed price. If it is possible to set a price, a method of determining a fair price at death is included in the agreement. *Editorial, Ohio State M.J., October, 1953.*

A very large percentage of tuberculous persons remain unknown to public health authorities, and their lesions are generally extensive and many months or years old when they finally come to medical attention. The fact that most patients are in a fairly advanced stage of disease when their tuberculosis is first diagnosed is of extreme importance, not only because it adds difficulties to their treatment, but, even more, perhaps, because it is responsible for giving these persons countless opportunities to infect; unwittingly, many of the human beings with whom they come into contact. *Rene J. Dubos, Ph.D., Am. Rev. Tuberc., July, 1953.*

# Meat...

## *and the Dietary Treatment of Gastrointestinal Disorders*

A recent study points out that patients with peptic ulcer, ulcerative colitis or regional enteritis can effectively utilize good quality protein from animal sources.\* Protein hydrolysates apparently are less effectively utilized than intact protein.

In patients with uncomplicated peptic ulcer on regimens providing intact animal proteins the patterns of amino acid excretion in urine and feces were similar to those in normal subjects. In patients with ulcerative colitis or regional enteritis the increased output of nitrogen and amino acids in the feces was attributed to loss of intestinal secretions, inflammatory exudate, and blood. Although the patients utilized intact animal proteins effectively, the authors suggested that an intake of more than one gram of dietary protein per kilogram of body weight might be useful.

On the basis of this study a dietary plan recommended for treatment of gastrointestinal disorders provides at least one gram, of protein per kilogram of body weight, but preferably more. Meat constitutes one of the important sources of animal protein in the plan.

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\*Kirsner, J. B.; Brandt, M. B., and Sheffner, A. L.: Diet and Amino Acid Utilization in Gastrointestinal Disorders, *J. Am. Dietet. A.* 29:1103 (Nov.) 1953.

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## RURAL PHYSICIANS

Many times one hears a remark that the reason for lack of doctors in isolated communities is that the doctors have a monopoly. We know that this isn't the real reason and although it is not exactly a public relations problem, our help in the solution would certainly be a step in the right direction. By urging communities to establish facilities for a doctor to practice good medicine, we are working with the public on an acute problem. It will be a stimulus to young doctors if they find desirable working conditions in small communities. Medical schools are beginning to again emphasize the good points of general practice. This trend should be encouraged. *Edward J. Guilfoyle, M. D., Presidential Address. Rocky Mountain M. J. Sept. 1953.*

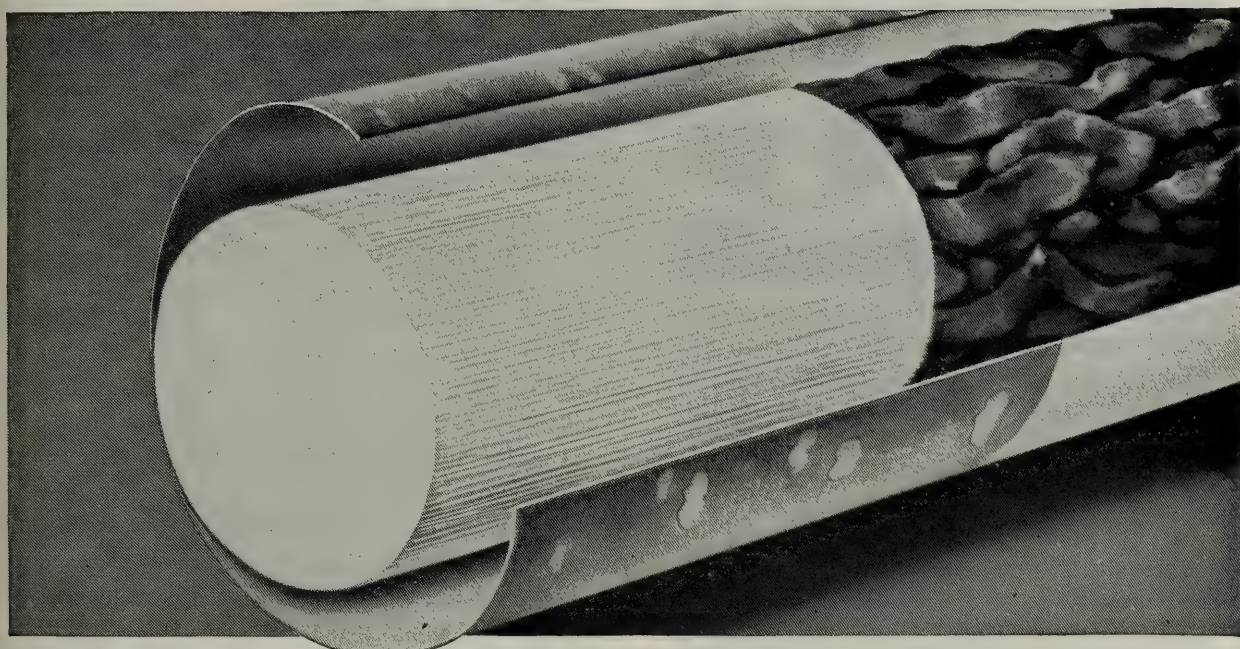
The segregation of mental patients with tuberculosis should present no difficult problem in most mental institutions. While separate buildings for these patients are preferable, a considerable degree of segregation can be provided in special wards of buildings housing other patients. *Julius Katz, M.D., Editorial, NTA Bulletin, Feb., 1954.*

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Most plantar warts are presumed to have the same etiology as warts on other parts of the body (verruca vulgaris). When they grow on a pressure point of the sole of the foot, however, most growth must be inward. Severe pain and disability may result, particularly if the plantar

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fascia is invaded. Possibly of different etiology are the mosaic plantar warts, which are flat and nonpainful and which have irregular outline. Paring of these warts reveals many individual cores, forming a pattern which leads to the term "mosaic." Mosaic plantar warts frequently occur in association with hyperhidrosis. *Walter K. Grigg, M.D., Gertrude Wilhelm, R.N., Epidemiological Study of Plantar Warts Among School Children. Public Health Reports, October, 1953.*

The indications for rest therapy during the active phases of tuberculosis are not altered by the proposals that patients may be treated with surgical collapse or resection, although if, after surgery, the inactive status is reached earlier it is evident that the total rest period may be somewhat shortened. Of all the agents ever employed in the treatment of tuberculosis, rest has stood the test of time and is today one of our most important weapons. Robert L. Yeager, MM. M.D., NTA Bulletin, April, 1954.

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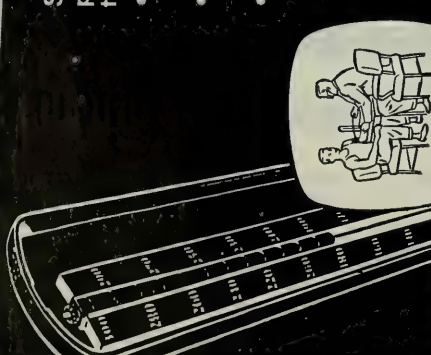
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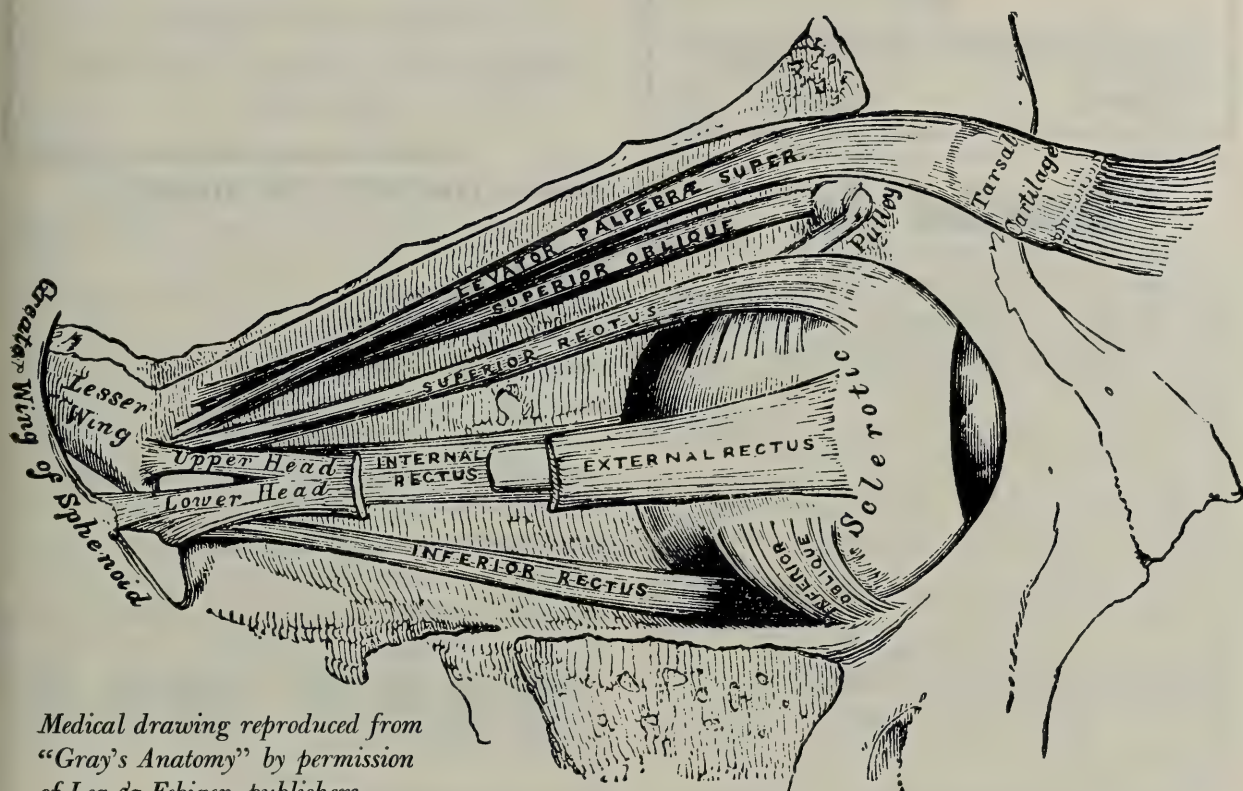
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# *The* ILLINOIS *Medical Journal*

Official Journal of the Illinois State Medical Society

Harold M. Camp, EDITOR.

Theodore R. Van Dellen, ASSOCIATE EDITOR.

Vol. 106, No. 2

August, 1954

## Poliomyelitis and Hospitalization

Archibald L. Hoyne, M.D.  
Chicago

When a diagnosis of poliomyelitis is made or that disease is suspected there should be a prompt decision on the action to be taken. This is because it may have a distinct bearing on the outcome of the illness. Ordinarily it would not seem extremely difficult to make a correct diagnosis of poliomyelitis. And in the midst of an epidemic one is justified in regarding almost every indisposition with suspicion at the onset. Even the fact that errors have been estimated as occurring in 30% to 40% of the cases should not lead one to any other conclusion.

Then the first question to arise is should the patient be taken to a hospital? Some authorities have recommended home treatment for most patients. Also physicians have been told that long trips in ambulances intensify the symptoms. In New York City it was emphasized that patients brought to hospitals from distant places were likely to be more severely ill than those who lived nearby. It was believed that the longer trips in ambulances contributed to this circumstance. But the general trend for poliomyelitis as in the case of other acute infectious diseases is to find the most susceptible victims in rural or suburban areas.<sup>2</sup>

Now if you are willing to concede that transportation of the patient is not likely to be harmful a second question is presented. Should there be no communicable disease hospital in your locality will a general hospital admit the patient? The hospital attitude in respect to this point

is often amazing and is based much more on fears than on facts. The rule against admission of poliomyelitis is often made by a lay board of trustees who decree that no contagious diseases shall be treated in the hospital. But we may ask is poliomyelitis actually contagious?

During a period of 40 years<sup>3</sup> there has never been a student nurse nor any one else associated with Cook County Contagious Disease Hospital who has ever contracted poliomyelitis. But one may state it has happened in other hospitals where poliomyelitis was cared for and none will deny that statement. Then shall our interpretation mean that this difference is explained by the perfection of medical aseptic procedures in County Contagious Hospital where, it may be mentioned, the wearing of face masks is optional?

If poliomyelitis is a contagious disease as first maintained by Wickman<sup>4</sup> about 1905 it is strange indeed that no one ever contracted it at County Contagious Hospital. Moreover if there should be such an occurrence it would be no proof that the disease was acquired within the hospital. In the midst of an epidemic of any disease which can not be controlled by active immunization hospital employees ordinarily are exposed to the same dangers of infection as the general public. Yet if any one associated with a communicable disease hospital develops a contagious disease it is usually assumed the hospital was the source of infection.

In 1952 the Illinois Department of Public Health included the following statements in its

Presented at Postgraduate Conference, Illinois State Medical Society, Quincy, Illinois, March 19, 1953.

"Recommendations for the Control of Poliomyelitis":—

- "1. There is no reason for exclusion of poliomyelitis cases from general hospitals if isolation is exercised — rather such admissions are necessary because of the need for adequate medical care by the patient.
- "2. Suspect cases shall be segregated from known cases until the diagnosis is established.
- "3. The importation of cases to hospitals in a community where poliomyelitis is not prevalent has not been demonstrated to affect the incidence of the disease in the hospital community."

Knowledge in respect to the epidemiology of poliomyelitis has made no progress of practical value since Wickman in 1905 maintained that the disease was spread by human carriers. But quarantine<sup>5</sup> and isolation of patients have had no discernable effect in the control of epidemics. All the common contagious diseases of bacterial origin have declined markedly. Measles, chickenpox and mumps, the three common virus diseases have remained more or less stationary and poliomyelitis continues to increase with improvements in nutrition and advances in sanitary measures. Moreover poliomyelitis thrives during warm dry seasons when transmissible diseases are usually at their lowest level. Scobey<sup>6</sup> of Syracuse, New York states that the only thing which makes polio contagious is the law. He believes that poliomyelitis may be caused by a toxin. However Rosenow<sup>7</sup> is still convinced that the etiologic factor is a specific streptococcus.

Previously I have intimated that every case or suspected case of poliomyelitis should be hospitalized. There are two principal reasons for this view. (1) If the patient has poliomyelitis there is no certain means of determining at the time of onset what course the disease may follow. Sometimes a patient who is not considered to be seriously ill will, a few hours later, develop bulbar symptoms which will make an emergency tracheotomy necessary to preserve life. Or with little warning the services of a mechanical respirator may become urgent. Under such circumstances if the patient has not been hospitalized promptly death may occur in the home or while en route to a hospital. (2) Hospital facilities may be of equal importance for the doubtful or

suspected case of poliomyelitis. A lumbar puncture may disclose that the patient is actually suffering from some form of meningitis which will respond to proper treatment. Or perhaps tetanus is the correct diagnosis. Typhoid fever with meningismus is still another and laryngeal diphtheria, diabetic coma and also instances of bronchopneumonia are conditions which have been disclosed by hospital examinations of patients who were believed to have or suspected of having poliomyelitis. If such patients had remained at home they would probably have died. Other diseases sometimes confused with poliomyelitis are mumps, asthma, rheumatic fever, brain tumor, brain abscess and a variety of less serious conditions.

When we consider the consequences which may result from keeping at home the poliomyelitis patient or one suspected of having the disease it would seem that the protection afforded by hospitalization should never be withheld. However this does not mean that a prolonged hospital stay is necessary for every poliomyelitis patient. In fact from 3 to 4 days would be sufficient in many instances. A lesser time might suffice if several days had elapsed from the onset prior to admission.

Even with very mild attacks of poliomyelitis there are many advantages to be gained from hospitalization regardless of its brevity. Not only can any helpful laboratory work be done but probably of much more importance a physical therapist can check the patient and will often find weakness in muscles which most physicians would not recognize.

There seems to be no doubt that among our so-called "non-paralytic" patients there are some who have a paresis of lumbar muscles which may not be apparent during the early stage of the disease. However unless detected soon such a condition may lead to a serious curvature of the spine. Therefore every non-paralytic patient should be examined periodically for several months and if there is any question in regard to an impending deformity the services of an orthopedic surgeon may be required.

As we are all fully aware there is no specific remedy for poliomyelitis. It is safe to conclude that human convalescent poliomyelitis serum which was used so extensively at one time is of

no value for treatment. The fact that convalescent sera contain antibodies need not influence such a decision. If we accept the prevailing opinion that poliomyelitis is caused by a virus and that this virus enters the nerve cells almost immediately after infection takes place it is easy to understand that convalescent serum can not be administered soon enough to subdue the virus which is entrenched from attack within the cell. It is almost entirely on that account convalescent serum for poliomyelitis has been abandoned in most communities. Another reason sometimes used against it is the fear of its causing an acute hepatitis.

The average non-paralytic and the spinal forms of the disease which are confined to the extremities require no special medication during the first week as a rule. Later some drugs are thought to promote relaxation of contracted muscles or as usually expressed now muscles that are "in spasm".

The idea that moist hot packs are going to restore the functions of paralyzed muscles seems little short of ridiculous. Nevertheless hot packs are still employed extensively. Moreover those who direct that they be used often seem to derive a great deal of satisfaction even if the patient gains no benefit.

During the first few days of the disease the application of hot packs, which means frequent disturbance of the patient, may be detrimental to his welfare. Later moist warm heat may be a helpful aid in relaxing tense muscles. However hot packs are not necessary at any time if patients can have the services of experienced physical therapists. Furthermore hot packs do not stay hot and when they become cold, if not changed, only add discomfort to the patient. In addition it must be kept in mind that if the packs are too hot they may cause serious burns. And there is still another factor to consider. The cost of equipment and nurses services is a gross extravagance if hot packs are not essential. And surely it is difficult to conceive how the wrapping of a wet blanket about an extremity is going to have a beneficial effect on a pathological lesion in the spinal cord. Notwithstanding the circumstances just cited the hot pack fetish seems to retain much of its early popularity.

For the acute stage of the disease there have

been reports that aureomycin<sup>8</sup> is beneficial. But there is no antibiotic that has received general acceptance for that purpose. The sulfonamides are considered contra-indicated by some clinicians. Rosenow is convinced that his antibody preparation — commonly referred to as a serum — has great value. However without intending to be unreasonably critical I think we must all admit that if a patient survives an illness he is almost certain to improve. Therefore one is not always justified in attributing the favorable outcome to the remedy that was prescribed.

In the case of poliomyelitis whatever paralysis the patient is going to have will become manifest, as a rule, within 3 to 4 days from the date of onset of the illness. There are exceptions of course where the paralysis continues to progress for as long as a week. Four days after onset in the spinal type of disease, the question usually is how much better will the patient be — not how much worse. It depends upon the amount of damage in the spinal cord.

Not infrequently someone asks "what do you do for the pain in the paralyzed muscles"? Of course the answer expected is — "apply hot packs". But if we give sufficient thought to this matter we soon realize that there is practically never any pain in the paralyzed muscles. For example we find that a patient with paralysis of a lower extremity will rest in bed in comparative comfort as long as he is not disturbed. However if there has been no physical therapy and the leg is lifted, perhaps only a few inches, there is likely to be an agonized expression on the face and probably an outcry of pain. But the pain is in the normal muscles which are contracted, or as we say now "in spasm", and it is the stretching due to the manipulation that is painful. A similar situation is presented in an upper extremity with deltoid paralysis when an arm is raised. Physical therapy applied early in the disease can accomplish much to lessen such contractures. A paralyzed arm should not be permitted to lie horizontal to the body; it should be kept at a right angle or nearly so.

The bulbar form and the respiratory cases are the ones which require the most exacting care and account for nearly all fatalities. One of the few real advances made in the treatment of poliomyelitis during the acute stage, applies to the bulbar type. There is no doubt that tracheo-

tomy is often a life saving measure. Nevertheless tracheotomy is not a necessity for every bulbar patient. It is often a matter of judgement whether or not the operation should be performed. However it is dangerous to falter if any question exists.

At the first indication of bulbar involvement postural drainage should be promoted by keeping the head on a level lower than that of the body. It must be remembered that because the muscles of deglutition are paralyzed the patient is unable to swallow and the secretions seep into the larynx and may cause drowning. An atelectasis may develop either early or late in the course of the disease.

In the tracheotomized patients if the oropharynx can be kept free of secretions by means of mechanical suction it should not be necessary to use suction so frequently through the tracheal opening. Continually inserting a catheter through the tracheotomy tube may cause a great deal of irritation and increased secretion which could be avoided. Patients whose entire nourishment is being supplied by means of intravenous fluids show a potassium deficiency. This can be treated by administration of potassium intravenously with much beneficial effectiveness. Oxygen inhalations are always indicated for bulbar patients. In some instances enzymatic substances are instilled through the tracheotomy tube for the purpose of liquifying tenacious secretions in the trachea and lower air passages. Rarely resort to the broncoscope is required to remove plugs of obstructing mucous.

Sometimes the tracheotomy tube is allowed to remain in place for an excessively long time to the disadvantage of the patient. The tracheotomy tube itself constitutes a foreign body in the trachea and may promote secretions by irritation of the mucous membranes. However the time for removal of the tube must be based on one's judgment and experience.

There are some unusual complications which perhaps should be mentioned. One is myocarditis which we have seen develop with little warning in respirator patients. Another very rare occurrence is perforation of the esophagus while patient is in respirator. This accident is probably brought about by a regurgitation of stomach contents which leads to the gastric juice causing an ulcer in the esophagus and eventually the

action of the respirator is instrumental in producing the perforation. There is still another rare "complication" which may be mentioned. It is a stone in the kidney or more likely in the ureter. In reality this is a complication of the treatment rather than of the disease. It is brought about by prolonged immobilization of the patient as may be necessary in a chronic respirator case.

Patients who must be kept alive by means of artificial respirations require the utmost care and constant watching. For successful treatment experienced nurses should be in attendance. Every effort should be made to prevent pressure sores and this applies to the back of the neck, when the patient is in a tank respirator with a close fitting collar, as well as to other parts of the body. The patient must be skillfully fed or may be obliged to depend on intravenous fluids. Portholes must be securely fastened so that there is no chance of one falling open. The cord from the electric current outlet must be firmly attached so that it cannot be disconnected by the stroke of a foot or perhaps by a maid who is mopping the floor. If extremities are paralyzed, which is likely, as well as intercostal muscles and probably the diaphragm also, the arms and legs should receive the attention of a physical therapist. The best stimulants the patient can have are cheerfulness and encouragement from those who come in contact with him.

In addition to the customary standard type of respirators there are also several different kinds which are portable. One of the most recent makes is known as "The Huxley". It is described as a chest-abdominal respirator and has been exceptionally satisfactory whenever we have used it. The rocking bed is also very helpful as a bridge between the respirator and breathing without mechanical assistance.

We now come to the big problem which lies before us with the oncoming poliomyelitis season. Due to the persistent and glowing publicity which gamma globulin has received as a preventive for poliomyelitis it is probable that most mothers will want their children "immunized" wherever and whenever poliomyelitis appears. Like many other "disclosures" pertaining to poliomyelitis in recent years the suggested use of gamma globulin as a prophylactic is not new.

A number of physicians have employed this blood fraction for protection against poliomyelitis during at least 6 or 7 years past. I have in mind particularly Doctor Frank Leeming, a Chicago pediatrician. Moreover there has seemed to be some convincing evidence of the value of gamma globulin. Now we have the results of the scientific tests which were carried out on a large scale in Utah, Texas and Iowa. Nevertheless it seems to me on the basis of the reports that the expenditure of millions of dollars, as planned, to promote a gamma globulin campaign of immunization may not be justified. It is a stupendous undertaking to produce and plan for a proper distribution of the material. However the National Research Council will undoubtedly make valiant efforts to meet the expected demand. The prophylactic dose will probably vary from about 7 c.c. to 10 c.c and the passive immunity last from about 6 weeks to 2 months. The more recent assertion seems to be that this prophylactic measure is not expected to prevent the disease but is intended to forestall paralysis. The next poliomyelitis season will be viewed with unparalleled interest.

In the past we have had a vaccine<sup>9</sup> of attenuated virus for poliomyelitis prevention but it proved to be dangerous. A little later another vaccine was developed which could be given with safety but without value. Not many years ago spraying the nostrils with zinc sulphate or other solutions was advocated to avoid infection. At

that time it was generally believed that the polio virus was inhaled by way of the nostrils and passed up through the olfactory bulbs to invade the central nervous system. Those who contended that the virus gained entry by way of the digestive tract were often ignored. Today it is stated that the olfactory bulbs are not involved in the infection but the virus may be obtained from the stools for many days after the attack. But this is not a new discovery. As long ago as 1915 Sawyer<sup>10</sup> reported finding the virus in fecal washings 16 days after the onset of poliomyelitis. But there is no public health requirement that the discharges from the body be disinfected before disposal.

COMMENT

Notwithstanding that millions of dollars have been spent in research the poliomyelitis problem becomes more complex year after year. It seems almost certain that the disease is spread in some other manner as well as by human carriers. The discovery of the Coxackie<sup>11</sup> virus and the finding of three types of poliomyelitis virus have added confusion to the diagnosis. Moreover Rosenow is convinced the etiologic factor is a specific streptococcus while Scobey believes that a toxin can explain the symptoms and pathologic findings.

There is no specific remedy for the disease nor reliable prophylactic measures for its prevention. Isolation and quarantine have been failures for the control of epidemics. Let us hope that gamma

TABLE 1  
COOK COUNTY CONTAGIOUS DISEASE HOSPITAL  
POLIOMYELITIS IN YEAR 1952

	NON- PARAL.	SPINAL	FAT. %	BULBAR- SPINAL	FAT. %	BULBAR	FAT. %
CHILD	97	114	0	18	11	38	7.8
ADOLES.	30	8	3	10	20	10	20.
ADULT	30	31	1.6	13	53	8	0.0
TOTAL	157	153	3.	41	26.8	56	8.9

PREGNANCIES

EARLY	3	CARRYING	3	NON PARALYTIC	3
LATE	1	ABORTIVE	1	PARALYTIC	1

TOTAL CASES AND DEATHS

		FAT. %
CHILDREN .....	267	1.8
ADOLESCENTS .....	58	10.3
ADULTS .....	82	8.5
TOTAL .....	407	4.4
		A.L.H.

TABLE 2  
COOK COUNTY CONTAGIOUS DISEASE HOSPITAL  
POLIOMYELITIS IN YEAR 1952

WITHIN	32 TRACHEOTOMIES — FATALITY 40.6%			
	48 HOURS	DEATHS	AFTER 48 HOURS	DEATHS
CHILDREN	8	2	6	3
ADOLESCENTS	5	2	2	2
ADULTS	8	2	3	2
TOTAL	21	6 (28%)	11	7 (63%)

11% (56) of 407 patients had bulbar involvement without other paralysis

10% (41) of 407 patients had both bulbar and spinal paralysis

23.8% (97) of 407 patients had bulbar involvement

32.9% (32 patients) of 97 with bulbar involvement had tracheotomies

A.L.H.

globulin will prove to be of more value for prevention than seems likely at the present moment. Thus far poliomyelitis is still unsolved and remains uncontrollable. Therefore it is necessary to concentrate on the best of treatment which can be provided only in a hospital.

The accompanying tables are self explanatory and the low fatality rates are a tribute to superior hospital care rendered by the nurses and physical therapists. The Cook County Chapter of the National Foundation for Infantile Paralysis also played an important role by supplying special equipment when needed and cooperating in every way possible.

428 Oakdale Ave.

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# The Use of ACTH and Cortisone in the Treatment of Bronchial Asthma

Leon Unger, M.D.  
Chicago

I have changed the title of my paper a little. Instead of talking on all the aspects of bronchial asthma, I will discuss today the use of ACTH and cortisone in the treatment of bronchial asthma. I have here two sets of reprints which you may have at the end of my talk, if you so wish.

When ACTH and cortisone were first introduced, they were not used in allergic conditions, as you know, but they are gradually finding their place in the field of allergy, and we are now able to point out the advantages and disadvantages from the use of these two hormones. This summary comes from our own experience up to this time as well as from those of others.

Great credit is due to the pioneers in this field, and hundreds of articles have already been published. Many of these have been reviewed by Evans and Reicherman, and by Ethan Allen Brown and, more recently, in an article by us.

ACTH and cortisone apparently do not cure, but they definitely can tide the patient over certain critical phases of some of his allergic illnesses. We believe that we now know how to use them, what the dangers are, and in which cases we can expect the best results.

An editorial in the *Journal of Allergy* gave a good summary after the first two years of use of these two hormones. The editorial said that ACTH and cortisone are two of the most potent drugs available for the temporary symptomatic relief of severe and intractable bronchial asthma. Within a few days, severely ill asthmatics may feel good, with a sense of well-being. Prolonged use, however, does not change the allergic state, and recurrences usually follow when the hormones are stopped. Nevertheless, they are welcome additions in stubborn cases which

have resisted the usual measures of treatment.

The editorial also points out that it is no longer necessary to carry out the complex and the numerous tests which at first tended to discourage their use by physicians who were not associated with large medical centers. Close clinical observation and ordinary modern laboratory facilities are still necessary. The relief of severe asthma usually far outweighs the possibility of serious side effects from these hormones.

Ambulatory treatment has been safely and effectively continued, when necessary, over weeks and months and even years, especially since cortisone is so effective by mouth.

The slow intravenous use of ACTH gives not only a quicker but also a greater therapeutic effect per milligram, thus lessening the cost to the patient.

These drugs seem equally effective in severe allergic contact and atopic dermatitis, but are less useful in urticaria. In conclusion, the editor says that ACTH, itself, contains protein, and instances of sensitization have occurred.

The remarks in this editorial, written a year ago, are still apropos today. I am not going to burden you with all of the literature on the subject, but I want to quote a paragraph from an article of ours which appeared in the *A.M.A. Journal* last October. This is on the treatment of bronchial asthma. "We have delayed discussion on the use of corticotropin, (ACTH) and cortisone in patients with asthma, because we believe that these hormones should be tried only if the standard measures — for example, administration of aminophylline and epinephrine — have failed. They should not be used routinely, nor should their use supplant careful allergic study and therapy."

In the hospital we usually begin with 20 milligrams of ACTH added to each liter of aminophylline in 5 per cent glucose, which is given by the slow, continuous intravenous drip. The patient usually receives about 2 to 3 liters per 24

---

Associate Professor, Department of Medicine, Northwestern University Medical School, Chicago.

Presented before the Section on Allergy, 113th Annual Meeting, Illinois State Medical Society, Chicago, May 20, 1953.

hours, with a total daily 40 to 60 milligrams of ACTH. This is less expensive than giving the usual 25-milligram dosage every six hours. The results have been brilliant in many patients with severe status asthmaticus; the asthma usually lessens promptly, the patient feels better, he eats better, he gains weight. If the patient continues to improve, the dose of ACTH is gradually reduced, or one can substitute cortisone given by mouth, usually beginning with at least 25 milligrams every six hours. This treatment must be continued over a long time, because the asthma usually returns if the treatment is suddenly stopped. In some patients the therapy has been continued for a year or more, and we have several patients who have been on it for over a year.

The usual precautions, such as low sodium intake, are absolutely necessary, and we always give 5 grains of potassium chloride after each meal for the larger doses of ACTH or cortisone, and gradually cut the amount of potassium chloride as we reduce the amount of ACTH or cortisone.

These hormones, ACTH and cortisone, provide us with an extra weapon, a powerful one that may promptly ease the suffering of asthmatics. Before starting the use of ACTH and cortisone, however, the physician should weigh the advantages — the more or less prompt relief which can be expected in most cases — against the disadvantages of the prolonged, expensive treatment, the difficulty in stopping, the possible reactions, and sometimes the failures which occur from the use of these two hormones. When a physician considers the matter thoughtfully, he will usually give ACTH and/or cortisone when he is forced to do so by fear of imminent death, or a case of status asthmaticus which has refused the usual therapy. However, he will not start treatment with ACTH or cortisone nor will he use them to replace therapy based on the allergy survey itself. In other words, if you can get by with the ordinary methods of treatment in allergy, that is the treatment to use. If you can't, if you have failed after using the ordinary methods, then you certainly are entitled to use ACTH and cortisone.

Now, which patients do we select for these hormones? We select two types of cases. First

of all, we include those asthmatic patients we think might die from the disease. Secondly, we use it in certain patients with contact or other types of allergic dermatitis where one cannot find the cause or seem to stop the process; the results have been very good in many patients in that group.

The contraindications for the use of ACTH and cortisone are just three, I think. One of them is peptic ulcer. That is a definite contraindication. Two of our asthmatic patients developed peptic ulcer while we were giving them ACTH and cortisone, and they complained of heartburn. We took X-rays, and the X-rays showed the ulcers. We stopped the ACTH and cortisone, and in both cases the X-ray evidence showed that they had recovered.

The second contraindication is any degree of psychosis.

The third is pulmonary tuberculosis, including patients who have recovered or are quiescent.

Those are the three absolute contraindications for treatment with ACTH and cortisone. Diabetes, high blood pressure and others are relative contraindications, and one must weigh the advantage of the ACTH against the disadvantages.

It is important to examine the patient for blood pressure and urine, and to ask him about any heartburn which he may be developing, and to look for edema and to weigh him regularly.

I might report one case before I finish. A woman from Kokomo, Indiana, came to the office with severe asthma, and with utmost cyanosis and dyspnea; she could hardly walk into the office; she was almost carried in by her husband.

We put her in the hospital at about two o'clock in the afternoon and gave her this intravenous, continuous ACTH with glucose — 20 units of ACTH with 5 per cent glucose in distilled water, every eight hours — and when I returned to the hospital the next morning, the woman was lying on one pillow, breathing easily, not cyanotic at all, and extremely grateful. She said it was the first time she had taken a good, deep breath during her twelve years of severe asthma.

That is what you can expect in some of these very bad cases.

We had another case involving a man who worked for the telephone company. I saw him at the hospital one day last week. Before that

we had to go out to his house to give him aminophylline and adrenalin in oil. We put him on cortisone after I saw him. He phoned in yesterday and he was back to work. Of course, he was not cured. ACTH and cortisone do not cure any disease, but they certainly are wonderful in some patients.

As I said before, only use ACTH and cortisone in those patients in whom you cannot get results

with normal allergy management. When you do use ACTH and cortisone, be sure to keep up your allergy management at the same time, so that later on, one will try to get along without the ACTH and cortisone. But do not be afraid to use those two hormones, if you use them correctly.

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# Treatment of Herpes Zoster with Cortisone

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Cortisone has been used effectively in a wide variety of pathological conditions, not the least of which has been the infectious diseases. Here its effectiveness is apparently due to its ability to protect the tissues from their own defensive mechanisms. For this reason, it is now used extensively in the treatment of eye infections and in certain diseases where the tissue reaction produces scars or lesions which may be harmful to the organism as a whole.

My attention was first attracted to its use in herpes zoster in a patient with involvement of the fifth cranial nerve in which the cornea had become ulcerated. Cortisone was started because of the eye lesion and it seemed that there was a more rapid resolution of the skin lesions, as well as a more prompt healing of the corneal ulcers, than would be expected with the conventional methods of treatment. This study was undertaken to see if this observation was borne out in a larger number of cases of herpes zoster, and to see if there was any demonstrable superiority of cortisone over other reported methods of therapy.

Any evaluation of this disease is made doubly difficult by its inherent vagrancies. Different cases of shingles vary as greatly in regard to locations, symptomatology and severity as do

the individuals who acquire the disease. However, the division into so-called primary and secondary types does not seem justified in view of the present knowledge of its virus etiology. Precipitating factors, whether local or general, are probably similar to those factors influencing the susceptibility to any infectious process. In appraising the response to treatment the patient's condition as a whole must be carefully considered, as this is undoubtedly of major importance in the recovery from herpes zoster.

The treatments of herpes zoster are legion, every physician seemingly having his own pet cure for the shingles. Among the agents which have been suggested, with varying results, are iron, arsenic, strychnine, gelsemium, valerian, aconite, liver extract<sup>9</sup>, tetra ethyl ammonium chloride<sup>16</sup>, dihydroergotamine-45<sup>5</sup>, Aureomycine,<sup>2, 3, 4, 8</sup>, thiamin<sup>15</sup>, foreign protein<sup>13</sup>, Chloromycetin<sup>3, 4, 6, 14</sup>, protamide, diphtheria antitoxin<sup>13</sup>, fever therapy<sup>1</sup>, local nerve block, paravertebral nerve block<sup>7</sup>, injection of distilled water and many others. It has been common experience for a drug to work satisfactorily in the hands of one investigator and to be totally unsatisfactory for a second.

In all likelihood the difficulty probably arises from the fact that the majority of cases of herpes are mild and will respond to any or no treatment, whereas the severe case is resistant to all forms

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of therapy. The investigator treating every case which he sees with his new mode of therapy will have good results statistically, but the physician attempting to duplicate his results only in those cases which have failed to respond to other means of therapy will be disappointed again. No treatment is specific at present and the accepted course of therapy to follow should include recognition of underlying precipitating factors and their proper management, relief of pain, control of infection and local treatment of the vesiculation when necessary.

*Methods.* — The present study includes fifteen cases which were treated either with cortisone alone, with cortisone and chloramphenicol, or with chloramphenicol alone. Eleven patients received cortisone alone, three patients received combined therapy and one patient received chloramphenicol alone. No attempt was made to select the cases and all degrees of severity were encountered. Two cases were considered mild, eight cases were considered moderately severe, and five cases were considered severe. In attempting to classify these cases into such categories the extent of the rash, the appearance of the rash and the amount of pain were the determining factors. Half of the patients received the cortisone by mouth and the other half received it intramuscularly. These patients were hospitalized only when the condition was severe, or where they could not be adequately followed on an out-patient basis. The average age of the patients was sixty-three years, with a range of from thirty to eighty-four. Age alone was not considered a contraindication to treatment.

Most of the cases were seen fairly early in the course of the disease, but one case had gone as long as fourteen days before treatment was begun. Each patient receiving cortisone was on a dosage schedule which included 300 milligrams in the first twenty-four hour period, 200 milligrams in the second twenty-four hours and 100 milligrams daily for a period of one to five days, depending on the appearance of the skin lesions. When chloramphenicol was used, 500 milligrams was administered every six hours for a period of forty-eight to ninety-six hours. Follow-up examinations of each patient were made either daily or every other day as long as necessary to determine the results of therapy. Such ex-

aminations included a review of the symptoms, inspection of the lesion and careful observation for the occurrence of side effects to the treatment.

*Results.* — As has been pointed out earlier, an evaluation of therapy in herpes zoster is made difficult because of the protean manifestations of this disease. The criteria of healing used in this study was drying of the rash without appearance of new vesicles and the symptomatic relief of pain. In no case was there any slowing of the healing process and the rash disappeared promptly in all cases; the average duration of the rash was 5.8 days in all cases and 5.6 days in those cases receiving combined therapy. Postherpetic pain is the most frequent and most disabling complication to this condition. Except in those instances mentioned below the pain subsided in about the same period of time required for healing of the rash. Two cases on cortisone alone had severe postherpetic neuritis. In both of these cases the pain was also resistant to deep x-ray therapy, vitamin B-12 in large doses, local nerve block or teroplerin. Relief came slowly after a period of six to eight months and was not appreciably altered by any of the therapy.

One case in which combined therapy was given had moderately severe postherpetic pain. No other treatment except analgesics was necessary. The one patient who had chloramphenicol alone had severe pain which subsided in about eight weeks. This was helped somewhat by deep x-ray therapy. Despite the fact that this group of patients was primarily of an older age, very few complications were encountered. The only side effect of any consequence which was noted was an elevation of the blood pressure in three patients. In two of these the rise was primarily in the systolic pressure and was not considered of sufficient magnitude to warrant changing the course of therapy. In one patient there was a rise of 60 millimeters systolic and 30 millimeters diastolic and cortisone was discontinued after three days. Recovery from the herpes zoster was still rapid. In none of these three instances was there any permanent blood pressure elevation.

A fourth patient developed a synovitis while under treatment with cortisone. Two patients with arteriosclerotic heart disease and hypertension received the usual dosage of cortisone

without adverse effect. One patient died while under treatment. He had a large carcinoma of the prostate and developed a urinary retention the third day after cortisone was initiated. A cystotomy was performed and the patient died on the first day postoperatively, probably of a cerebrovascular accident.

COMMENT

In the only other instance in which cortisone has been mentioned in regard to its use in herpes zoster the conclusion was that it was contraindicated; however, no evidence was given to substantiate this conclusion.<sup>11</sup> From this series it has certainly been shown that no hard and fast contraindication exists in its use in herpes.

Healing of the skin lesions occurred as readily as in other reported series<sup>2,3,4,6,8,10</sup> and there was no appreciable increase in the incidence of postherpetic neuritis. It is generally agreed that this latter complication is more prone to occur in the older age group, but no definite figures as to incidence are available for purpose of comparison. In round figures the neuralgia is a serious factor in between twenty to twenty-five per cent of the elderly group of patients. After cortisone therapy there were two of eleven patients who had relatively severe pain which eventually cleared. Thus, it does not seem that any definite advantage is gained by the use of cortisone. It was hoped at the onset that cortisone might alter the healing process in such a way as to prevent the formation of scar tissue in the dorsal root ganglion, as this has been offered as the explanation for the persistent pain of the postherpetic syndrome. A different dosage schedule, more prolonged therapy or an evaluation of more cases might throw more light on the value of cortisone in this syndrome. In cephalic herpes the incidence of postherpetic complications is said to be around fifty per cent.<sup>12</sup> In the one such case in this group no complications were seen and no scarring occurred in visible tissues. In the other patients of the series the rash was readily controlled and there was no appreciable postherpetic scarring of the skin. It would seem then that cortisone is partially effective in preventing the occurrence of scar tissue, but whether it can effectively prevent scar formation in nerve tissue is seriously questioned. Further observations may help to clarify this point.

In the limited number of cases in which chloramphenicol was used, either alone or along with cortisone, no significant difference was noted in the outcome. No serious secondary infection was found in any of the cases, but this certainly could alter the outcome of this disease. Chloramphenicol may be of value in controlling secondary infection, but there seems to be no justification for its routine use.

SUMMARY

Fifteen cases of herpes zoster were treated with cortisone, cortisone and chloramphenicol or chloramphenicol alone. There was no proven superiority of any of these courses of therapy. There were no adverse effects from the use of cortisone. Though it could not be definitely established that cortisone held any special advantages, it was felt that in those cases in which scar tissue formation might prove to be a serious side effect, the use of cortisone warrants further trial. In ophthalmic herpes cortisone is felt to be of real value. There is probably no justification for the routine use of cortisone or chloramphenicol in the uncomplicated case of herpes zoster.

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# Acne

## Some Recent Concepts of Etiology and Management

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The cause and cure of acne vulgaris cannot be covered adequately in a short paper. This task is analogous to that of the 23 year old female who has had acne for 7 years. She came into my office on Friday, said she was getting married on Sunday, and wanted me to clear her complexion for the wedding. She had just finished her menstrual period during which she had experienced a flare-up, and there were innumerable other details to occupy her attention. In addition, she was quite nervous about the whole affair which caused her to pick at her face.

There are no magic prescriptions for cure. All the texts offer remedies and though they are not magic, the principles of therapy are there. Nevertheless, the family physician has available practically all the therapeutic agents of the dermatologist, with the possible exception of x-ray therapy, and usually a good deal can be done for these patients through persistent effort.

One of the most important points I can make is a strong plea that these patients ought not to be turned away with the statement "You will outgrow it" or "It will disappear when you get married", or make light of the condition in other ways. Meantime, the patient is subjected to psychic trauma and disfigurement at a time of life when he is confronted with innumerable other emotional and social adjustments, to say nothing of the increased hazards of permanent scarring as a result of no treatment or mistreatment. It is not possible to know in the early stages of acne which cases will be mild and subside early and spontaneously, and which will suddenly go on to a severe scarring form. Nevertheless, we see many patients who were told a few years before to forget about it, and unfortunately they do. Then finally they come to the office in a state of dejection with many active lesions and permanent scars. We should assume that the acne patient who comes to us

willingly and is not dragged in by his mother has a problem that is bothering him, wants help, and will be co-operative, and it is our duty to help him as best we can.

No single causal factor has been established. Much of our present knowledge of the cause is based on circumstantial clinical observation such as the onset at or after puberty, menstrual flares, and absence of acne in castrates. Nevertheless, these clinical observations and resultant theories have been and are being subjected to experimental evaluation in many centers, and I believe will lead eventually to causal cure.

According to modern concepts, acne vulgaris results from the *combination* of three main mechanisms:

1. Local susceptibility to plugging of the hair follicles and sebaceous glands.
2. The hormonal stimulus which may be one of the principle factors leading to plugging. Acne apparently is the result of influences attributable to the development of the gonads and the steroid hormones, and it is especially in this field that investigations are being carried on.

3. Susceptibility of the obstructed follicles and sebaceous glands to cyst formation and infection.

How much of a part the hormonal stimulus plays in the first and third of the main pathogenetic mechanisms, and how much of a part other factors play, still remains to be established accurately. Though probably not causal, anemia, hypothyroidism, faulty dietary and living habits, and foci of infection, may contribute to the severity of the condition, and these conditions should be sought out and corrected where possible.

Logically, since acne vulgaris seems due in large measure to hormonal effects, causal treatment should consist of endocrinologic management. As yet, the magazine "Seventeen" and other lay publications to the contrary, this plan has not proved a panacea. Nevertheless, in certain cases hormones can be helpful.

Indications for administration of female hormones in acne are:

a) Accurate history of menstrual exacerbations.

b) Female over 18 with obvious masculine secondary sex characteristics.

c) Male or female with severe or intractable acne.

The forms of medication most commonly employed are Premarin and diethylstilbestrol. The most logical therapeutic schedule would seem to be one covering the hypoestrogenic phase of the menstrual cycle, i.e., from 5 to 7 days preceding to 3 to 5 days following the period. However, others have suggested administration from 7 days following menses to onset of the next period. Actually, the most effective period of administration, as well as dosage, seems to vary from patient to patient and requires some individualization. Conservative doses are the rule in initiating therapy. Signs of intolerance must be watched for and we must be prepared for phone calls from worried mothers who are fearful lest daughter be pregnant because her period is late. When hormonal therapy is effective, 4 to 5 months are required usually for much improvement to be noted.

Concerning other systemic measures, dietary recommendations have been so varied that it is difficult to judge which is best. Routine elimination of chocolate, nuts, cheese, and excess fats is generally accepted. In general, the fewer foods the adolescent must avoid and still achieve improvement, the more likely he is to cooperate.

*Vitamin A* is necessary for normal follicular keratinization. Better absorption and lower dosage levels are possible with the newer aqueous forms, but prolonged administration is still required to accomplish improvement. Here, as with estrogens, some patients are helped by *Vitamin A*. However, it is not possible to tell in advance which given patient will improve. At least 50,000 units daily for a period of at least three months usually are required. In general, this medication seems to be of more value in comedo-papular acne than in the pustular type.

Systemic measures, though useful and often important adjuvants, have not solved our problem, and the treatment of juvenile acne still depends on symptomatic and empiric measures

directed at remedying local conditions. It is in this field that we accomplish most. Assuming that we have a cooperative patient, it is necessary that we inform him that improvement may not be rapid, and that persistent and conscientious effort is necessary on his part. Otherwise, he may soon become discouraged. However, if logical local therapy is carried out, there is usually at least some degree of improvement.

1. Frequent cleansing in order to unplug the follicles by repeated removal of excess keratin and sebum is the most effective single home treatment. Most ordinary toilet soaps will accomplish this.

2. Topical applications containing sulfur and resorcinol are used primarily to produce peeling and to depress the activity of the sebaceous glands. For daytime use, it is preferable that these preparations be either clear or flesh tinted, for obvious (or rather unobvious) reasons.

3. Control of concomitant seborrheic dermatitis of the scalp is desirable.

4. Drainage of cysts at the proper time and by a technique inflicting minimal tissue damage can help minimize scarring.

5. Ultraviolet therapy may be beneficial due to its peeling effect, but the results usually are temporary.

6. X-ray therapy is being used somewhat less as knowledge increases concerning the treatment of acne, but the present consensus still dictates radiation as the most effective single modality. X-ray is perfectly safe when administered by a fully qualified dermatologist. Unfortunately, many cases of severe and disfiguring acne are being deprived of this treatment simply because the patients, their parents, and others have been led to believe that x-ray is always dangerous, no matter how small the dose. X-ray therapy does not increase scarring, which results from the acne process itself. Sulzberger has shown, through a review of several thousand cases checked after a period of many years, that the results were better and the permanent sequelae fewer in those properly treated with x-ray than when this modality was withheld.

Relative indications for x-ray therapy are:

- 1) Persistence over 17 years of age
- 2) A severely scarring active process
- 3) Failure of usual measures

Back to our girl sitting in front of us who is

getting married Sunday. What can we do for her? Depending on the type of acne she has, if she will delay the wedding, possibly a good deal can be done in a short time with the antibiotics. Not all cases are responsive to this mode of treatment. The severe pustular, nodular, and cystic cases show the best response. The fact that no bacterial growth can be obtained on culture from some cases with evident pustules, may explain the failure of response in some patients. Terramycin, aureomycin, and erythromycin have been used with about equal results. Some of the newer and safer sulfas also have been effective when administered for a sufficiently long period. Long acting penicillin injections may prove most economical. Eight of 14 cases treated by me with terramycin showed a good response, as did seven of 11 treated with erythromycin. However, this was given in short courses of only a few weeks and relapses were the rule unless antibiotic therapy was followed by the usual acne therapy.

If it works, you have a grateful bride. If it doesn't you have several angry families. However, there seems to be no better early approach for the extremely severe case.

#### DISCUSSION

Robert M. Goodwin, M.D.—Dr. Rubin is to be congratulated for squeezing into ten minutes so much information, good sense, and good humor on a problem that has plagued physicians, parents, and perhaps even ourselves as youths. I am supposed to discuss this paper and this implies criticism, but I can see nothing that doesn't call for the Amen of all physicians. Therefore, I am going to take the liberty of adding a few brief thoughts of my own on the same problem.

I practice downstate, where the larger part of the population are of northern European stock, veritably pink men. It is my impression that these people do not suffer in so great proportion the severe, pustulated, indurated, cystic type of acne. This seems to be more the burden of people with darker complexion. My own management for such severe cases which have been unsuccessfully treated by other means is drastic. I put these patients to bed, unless they are working for their bread. Sedation with any of the barbiturates, cold boric acid or dilute aluminum acetate soaks (perhaps this is psychotherapy; certainly

it is hydrotherapy). In addition, now that we have them, the safe and prolonged acting antibiotics mentioned by Dr. Rubin. I believe this regimen, when it works is successful only because the metabolism is reduced practically to the basal state, allowing the body to mobilize fully its recuperative powers.

Speaking of antibiotics, it can be said that if ten patients are given terramycin or aureomycin, at least six will develop untoward reactions involving the intestinal tract or the skin, particularly the congenital region. If chloromycetin is used, one in a million is likely to run into aplastic anemia. The physician is thus given the choice of antibiotics, and the patient the opportunity to choose his calamity. Since chloromycetin is not dramatically effective against skin cocci, my choice is the long acting penicillin, Bicillin, which can be given to unselected patients with a skin reaction chance of about one in fifty. Selecting the patients reduces even further the number of reactions.

There is a remedy so simple and so often effective in the more moderate type of acne that despite Dr. Rubin's injunction not to search his speech for pearls, but rather to go to the literature, I am going to drop this one. I refer to quinine sulfate, or bisulfate, in 2 grain doses three times daily for six to eight weeks. Incidentally, it is interesting to note that since I have quit warning the patients they might have ringing in the ears from quinine, the incidence of this reaction is steadily approaching the vanishing point.

A word about x-ray, and its role as the single most effective remedy in some vulgaris. Dr. Rubin mentions that this should not be used until the patient is at least 17. I wonder if this rule, which is standard in dermatology, is not predicated more upon legal than upon medical reasoning. Consider the pubescent child rendered unbeautiful by superficial pustules, oil pouring from the skin, and dilated and plugged follicles. On his first visit to the office the physician lays out for him, no matter how abbreviated, certain dietary and hygienic rules, and he is told not to expect wonders, and he is told that it will take some time to improve, and even more time to reverse his condition. And he does return to the office for several weeks and there is little improvement. Faith is lost, so he decides to go back on almond Hershey bars washed down with a quart of farm milk and quietly enjoy himself in front of the bathroom mirror by picking pimples, as he used to before he went to the doctor. Is it worthwhile to give these children two or three fractional x-ray treatments which *will stay* the steatorrhea and give them some definite improvement in a reasonable length of time, and justify their sacrifices? After all, the child with moderately severe acne is biologically older than 12 or 13, or he wouldn't have acne, would he?

# Allergic Rhinitis

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There are three types of allergic rhinitis, depending upon the factors in its etiology. These are, first, seasonal, which is caused by sensitivity to the pollens and molds; secondly, the bacterial; thirdly, the non-seasonal, in which the causative factors are those things present in the patient's environment throughout the year.

The most common type is the non-seasonal rhinitis, in which there is a history that runs something like this: The patient, often a child, has had many attacks of what appeared to be head colds. These come on in the fall, and clear up only to recur at irregular intervals throughout the winter. They gradually subside with the onset of warm weather. These colds occasionally recur during the summertime, but the summer symptoms are not nearly so severe as the winter ones.

This type of case is liable to be caused by one or more of a group of factors which come under the heading of non-seasonal inhalants. These include such things as the dust from the cotton linters of mattresses, the danders of animals and birds, feathers in pillows, and from a pet bird, cow dander from waffle-type hair rug pads, and occasionally some of the more uncommon miscellaneous factors such as pyrethrum, orris root, tobacco smoke and many others.

Of the seasonal type, true hay fever is caused by the pollen of grass, and occurs during the pollination period from early May through the first week of July. This is also commonly called rose fever, because it occurs when these flowers are blooming. So-called ragweed hay fever is the most common, and is due to the pollen of ragweeds, and also, often, those of the cocklebur, and Burweed Marsh Elder in this part of the country.

Much less common than the other two is the early hay fever which occurs during the months of March, April and May, and is due to sensitivity

to the pollen of trees. The various trees do not pollenate all at the same time. Among the earliest pollinators are the poplar and elm, and among the last are the oak, sycamore and hickory.

Among the common pollens causing trouble, oak is by far the most important in this area. Pollen sensitivity often causes more watery discharge and itching and redness of the nose than the perennial inhalant factors, and sneezing is often a prominent feature. In the treatment of this, group sera plus a good antihistaminic or cortisone during the acute attacks is still the best type of treatment and will give the best results.

A patient whose symptoms begin with the onset of warm weather and continue throughout the summer into the early fall months is likely to have mold sensitivity. The presence of symptoms during the middle and latter parts of July is indicative of this type of sensitivity.

In this part of the country the most common and the most potent molds are the Dermataceae, and the most important of these are *Alternaria* and *Hormodendrum*. There are many other molds, however, this group represents to the molds what the ragweeds do to the pollens.

Mold sensitivity is also suspected when a patient volunteers difficulty when around barns or any damp, musty surroundings, such as fruit cellars or a damp basement. Some patients who are extremely sensitive to mold spores will have year-around symptoms, although these are not common.

The severity of mold and pollen rhinitis varies according to the change in several factors. A variation in the mold and pollen count usually produces a marked change in symptoms. A dry, warm day, with a fairly steady, strong wind, will increase the amount of pollen and mold spores in the air tremendously, and this will be followed by an increase of symptoms. On the other hand, a cool, damp or rainy day will suppress the production of pollen, and this will cause relief of symptoms.

Another variant is the chilling of the body by

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cold air, cold drinks or a cold bath. Warming of the body, on the other hand, with warm drinks, especially hot coffee, generally relieves acute symptoms. It is also noted that patients have less severe symptoms during the end rather than the beginning of the season. This is probably due to the absorption of the pollen and mold protein into the system, and really is a naturally occurring partial immunity.

Contrary to what many people think, the pollen of flowers rarely causes hay fever. The so called rose fever, as mentioned before, is due to either grass or a mold sensitivity. The odors of flowers in a room may cause nasal irritation in an extremely sensitive patient, however, this is not a true pollen sensitivity.

House dust is probably the commonest single cause of perennial rhinitis. The major factor in house dust is the dust produced by the aging of the cotton linters found in mattresses and in upholstery. This dust seeps onto the floor and is spread by air currents and by being circulated throughout the house by means of hot air furnaces, especially those with forced-air draft. The house dust factor causes trouble during the cold weather, when the house is closed up and the heat is circulating the dust throughout the house, and more time is spent inside.

House dust is a seasonal inhalant, in that there is often a flare-up of symptoms during the cold weather and a gradual subsiding of symptoms when the warm weather of late spring returns. Occasionally an unseasonable cold spell in late spring or in August will require the turning on of the heat, and this may cause a temporary acute flare-up of symptoms.

This house dust factor is best controlled by covering the mattresses in the house with a plastic, air-tight cover, or replacing cotton mattresses with those made of foam rubber. Getting rid of heavy draperies and dust-catchers of any sort will help rid the house of this dust factor, but the primary consideration is the encasing of the mattresses.

Cleaning the hot air pipes in the early fall will eliminate much of the dust. Turning up the heat and starting the fan blower will often stir up dust in the pipes so it can be blown outside on a warm day, with the windows kept wide open.

It must be remembered that many people are

sensitive to a dust concentration in 1 to 1000 dilution because of its irritating properties, so a positive intradermal test in dilution more concentrated than 1 to 10,000 does not necessarily indicate a positive test.

Feathers is another common cause of rhinitis of the non-seasonal type. Here pet birds must be gotten rid of, and feather pillows must be encased in an air-tight plastic cover, or foam rubber pillows may be used.

Often a patient will have a feeling of false security in the use of a foam rubber pillow. I have seen a number of patients who have been found to be sensitive to feathers who substituted foam rubber for their own feather pillows but did not consider replacing the feather pillow of the mate in the same bed or a nearby bed in the same room.

Often feather upholstery in chairs and sofas must be replaced by foam rubber cushions.

Among farmers there is a factor causing rhinitis which is not generally seen in urban dwellers. This is grain dust, or grain mill dust. It consists primarily of molds and the fine portions of the grain husks. The patient complains of rhinitis when working around grain elevators, while shoveling grain, or occasionally being in storage bins or haymows. Since it is impossible for a farmer to avoid this kind of exposure, it is fortunate that these patients generally get good results to specific desensitization with mixed grain extracts.

With respect to animal danders, the only feasible treatment is to get rid of the source of the dander. This occasionally means getting rid of a favorite pet. However, if the patient is having severe symptoms, this must be done.

I have had little experience with the desensitization of patients to animal danders where the source of the dander was not removed. Those I have treated under these conditions have not gotten particularly good results. The danders of animals are very potent allergens, and should never be underestimated.

Occasionally a person moves into a rented apartment or house and has a sudden acute flare-up of rhinitis. The dander of a cat or dog which may have remained from a house pet of the former tenant should always be considered as a possible factor in those cases.

The best results from all these sensitivities are

obtained when the patient is removed from the allergen or when the offending allergen is removed from the patient's environment. Sometimes this allergen is transported to the patient from some distance away, and therefore the source of the particular agent is not evident. For example, I saw a patient in my office a couple of years ago who had had respiratory symptoms for several months. He was tested with the usual inhalants and showed positive reactions to the dander of cows.

On further investigation it was brought out that the father, who was a livestock commissioner and who often went into the animal pens during the sale of these animals, had begun to leave his coat in the closet next to that of the son. The boy was relieved of symptoms when his father began hanging his coat in the garage and changing his outer garments before coming into the house. The boy has had no symptoms since that time.

In my experience I have not found that foods are a major factor in the production of allergic rhinitis. In this I know that I disagree with many allergists. I do not doubt that the child or adult who has rhinitis due to an inhalant factor, and who is also allergic to one or more foods, may have an aggravation of the symptoms when he eats the food to which he is allergic. However, it has been my experience that in these cases of food sensitivity, there is usually an inhalant allergen which is the major factor in production of the symptoms.

Food sensitivity is much more important in the first few years of life, and most cases of allergic rhinitis that can be partially attributed to foods will be found in this age group.

Among the common complications of allergic rhinitis are sinusitis and otitis media. This latter is frequently found in children as a result of occlusion of the eustachian tubes by the edema of the naso-mucous membrane.

Another complication of prolonged untreated allergic rhinitis is the formation of nasal polyps. These generally follow prolonged irritation to the nasal mucosa by an inhalant allergy or bacteria or secondary infection. In my experience,

the prevention of the regrowth of nasal polyps is a difficult task. The treatment here should be directed to finding the factors causing the mucosal edema and eliminating them, or desensitizing the patient to them.

In those patients who do not respond to specific therapy, the question comes up as to the advisability of moving to a dry, hot climate, such as Arizona or New Mexico. Patients with acute seasonal rhinitis, due to pollen or molds or those patients whose symptoms are primarily bacterial, will generally benefit from a change of residence to this type of climate, or to the mountains or seashore.

Those patients in which the main causative factor is house dust or some other non-seasonal inhalant are not generally helped much. Any improvement in these patients is probably due to the reduction of the exposure to other offending agents, such as fumes and smoke.

Those patients who do not do well on specific treatment or who need an excuse for a vacation to the North Woods or the mountains should plan to stay until the pollen is greatly reduced. Some of the most difficult cases to treat are those children who have been north during first part of the ragweed season and are forced to return home at the beginning of the school year, before the ragweed count has started to decline. If the patient returns before the hay fever season is over, he often has an acute flare-up, which may be worse than it would have been if he had remained home during August and September.

In closing, I would like to emphasize that in the diagnosis and successful treatment of any allergic condition, a thorough history is of utmost importance. Skin tests often confirm impressions obtained from the patient's history, but can never take the place of an accurate history, including the activities, hobbies, any improvement noted on trips away from home, and seasonal changes in his symptoms. This knowledge of the patient, coupled with a determined program of therapy, will give good results in most of these cases.

333 Jefferson Building

## CASE REPORTS



# Methimazole Granulocytopenia

**J. Louis, M.D., L. R. Limarzi, M.D., and William R. Best, M.D.  
Chicago**

Since the original report, in 1949 by Stanly and Astwood<sup>1</sup> on the treatment of thyrotoxicosis with methimazole seven cases of granulocytopenia and agranulocytosis have been reported.<sup>2,3,4,5,6</sup> During the last three years we have had the opportunity to study two cases with hematologic complications during methimazole therapy for thyrotoxicosis.

The first patient, a 52 year old, white female was admitted to the surgical service nine months previously where the diagnosis of thyrotoxicosis was established by physical and laboratory findings. She received 300 mgm. daily of propylthiouricil for 78 days. It was then voluntarily discontinued because of the onset of a cold. Two weeks later upon returning to the clinic she was given 30 mgm. daily of methimazole. At this time the leukocyte count was 4,600 cells/cmm, 43 per cent neutrophils, 43 per cent lymphocytes and 2 per cent monocytes. On the 36th day of methimazole therapy, Lugal's solution was added to the medication in preparation for surgery.

The patient was asymptomatic until one week prior to admission when she developed sore throat, sharp pharyngeal pain on deglutition and jaw movement, sensation of a swollen tongue and malaise. The severity of these symptoms caused the patient to discontinue her methimazole (30 mgm. daily) on the eighty-fifth day of therapy. The next day she developed feverish sensations, and dull, bilateral retro-orbital aches. Two days later she developed stiff neck and constant dull left ear ache. Her symptoms progressed until the morning of the seventh day of her illness, the pain in her throat greatly increased. The patient then came to the hospital. On admission she was acutely ill with a fever (101°F. oral), pulse 102, respiration 20 and blood pressure 120/70 mm. of Hg. The skin was warm and moist. Marked trismus was present. The tonsils and pharynx were injected and edematous. The tonsillar crypts were filled with a yellowish exudate. The cervical lymph nodes were enlarged and moderately tender. Few beta hemolytic streptococci were found in the nose and throat. Bone marrow had a maturation arrest of the granulocytic elements, with increased

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From the department of medicine, University of Illinois, College of Medicine. This study was supported by a grant from Armour Laboratories.

TABLE 1  
BONE MARROW FINDINGS  
IN METHIMAZOLE GRANULOCYTOPENIA

Days	Patient I		Patient II		Normal
Following Admission	1st	10th	37th	64th	Values
<b>Granulocytic Series:</b>					
Myeloblast	2.0	1.0	6.0	0.6	1.23
Leukoblast	12.5	1.0	5.0	2.4	1.44
Promyelocyte	33.0	6.0	19.5	5.0	1.80
Neutro-myelocytes	12.5	16.5	15.5	11.8	16.46
Neutro-					
metamyelocytes	0.5	33.0	13.5	13.2	} 23.27
Stab forms	0.0	16.0	2.0	7.6	
Segmented					
neutrophils	0.0	7.0	0.0	7.8	12.90
Eosinophil	0.0	1.5	10.0	7.4	3.58
Basophil	0.0	0.0	0.0	0.0	0.06
<b>Erythrocytic Series:</b>					
Pronormoblast	0.0	0.0	0.25	1.4	0.47
Basophilic normoblast	4.0	0.5	2.0	4.4	1.69
Polychromatic					
normoblast	26.5	11.5	13.2	30.0	18.20
Orthochromatic					
normoblast	0.0	0.0	0.0	0.0	2.72
Monocyte	0.5	0.5	0.5	1.0	0.09
Lymphocyte	5.5	7.5	11.8	6.2	16.03
Plasma cell	3.0	2.5	0.0	0.6	0.15
Megakaryocyte	0.5	0.5	0.2	1.0	0.20
Granulocytic-					
Erythrocytic ratio	2.3	6.4	4.5	1.6	2.94
Maturation Index	120.0	0.43	2.97	0.69	0.20

numbers of toxic granules. The granulocytic-erythrocytic ratio was reduced, and the maturation index was increased (See Table 1).

On admission the patient received 300,000 units of aqueous procaine G. penicillin. Six hours later she developed a generalized urticaria and pruritus. The penicillin was then replaced by one gram daily of aureomycin. On the second hospital day she was able to eat, the leukocyte count rising from 1000/cmm. with 20 per cent neutrophils to 1800 cells/cmm.<sup>8</sup> She became afebrile on her third hospital day. The tonsils and pharynx became clear by the sixth hospital day. The leukocyte count was normal on the eighth day. The subsequent course was uneventful. The bone marrow eleven days after admission showed an increase granulocytic-erythrocytic ratio with a normal maturation index.

The second patient, a 24 year old, chinese, female, post-graduate chemistry student, was admitted to the hospital because of a progressive three month history of unilateral exophthalmus and symptoms from hypermetabolism. The diagnosis of toxic diffuse goiter was made. She was given daily 30 mgm. of methimazole. On the fourteenth day of therapy a 104° F. oral temperature occurred. Methimazole was discontinued. The next day an erythematous urticarial erup-

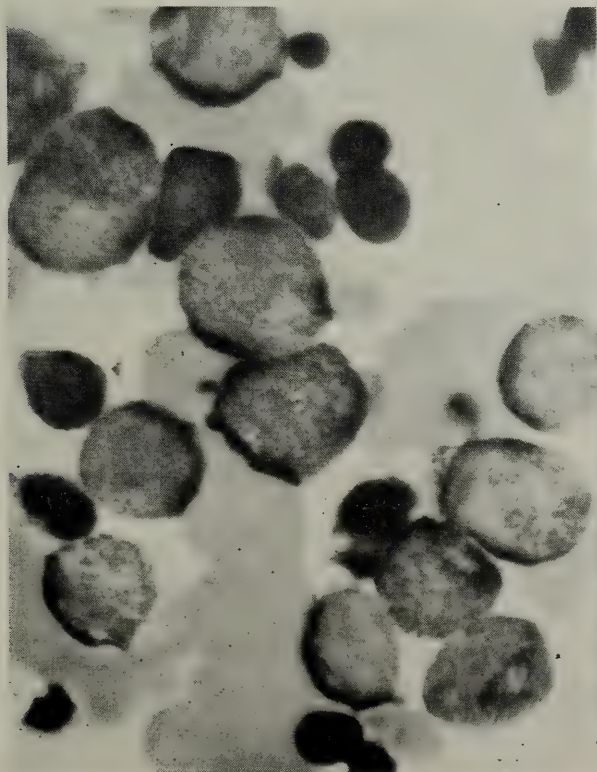


Figure 1. Bone Marrow (sternal smear) Case 1, showing toxic left shift of granulocytes (Maturation Arrest).

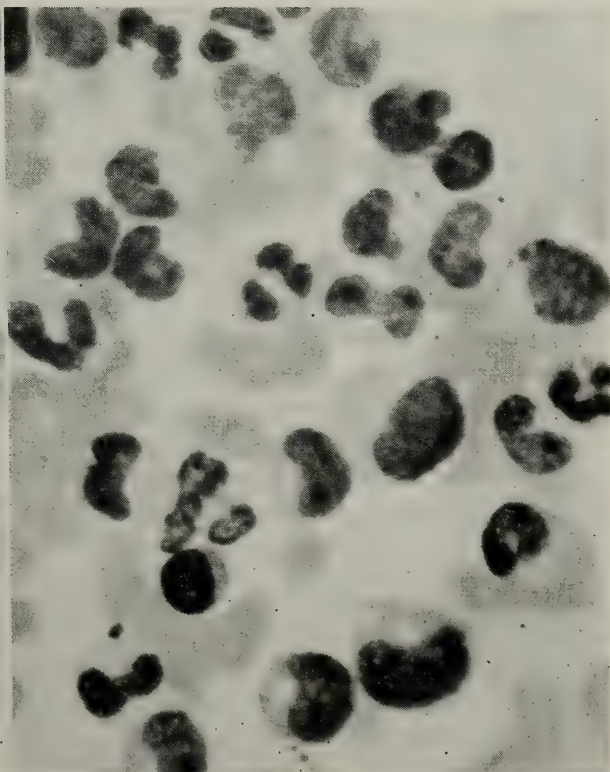


Figure 2. Bone Marrow (sternal smear) Case 1, after recovery showing normalization of granulocytic elements.

tion appeared on the lower extremities, lasting only twenty-four hours. During this interval she became afebrile. She was then given methimazole, 15 mgm. daily. Subsequently, her leukocyte count decreased. The patient, however, remained relatively asymptomatic until the seventh day of reduced methimazole therapy when she developed a generalized erythematous urticarial eruption, associated with severe pruritus. Methimazole was again discontinued. A neutropenia was now becoming evident, white count 3600/cmm. with 36% neutrophils. The eruption and pruritus continued for six days at the end of which she was given two doses of 500 mgm. propyl-thiouricil. The next day an intermittent fever of 104°F. developed with marked neutropenia; white count 3200/cmm. with 7% neutrophils. The bone marrow was hypercellular. The granulocytic-erythrocytic ratio, maturation index, and basophilic nuclear granules were increased (See table). Liver function tests were normal. All medication was stopped. The patient gradually became relatively asymptomatic four days later. She was prepared for surgery with Lugal's solution. The thyroid was subtotally removed on the sixtieth hospital day. The bone marrow on the fifth post-operative day was normal.

#### DISCUSSION

Bartels and Sjogren<sup>2</sup> reported one patient who developed stomatitis while receiving methimazole. In the patient described by Stone, et al<sup>6</sup> the bone marrow was described as reactive. Croke and Berry<sup>3</sup> observed a hypocellularity of the granulocytic elements with a relative increase in the erythroid and lymphoid cells. Specht and Boehme<sup>5</sup> described the bone marrow at autopsy from a patient who died from methimazole agranulocytosis. There was hypoplasia of the granulocytic elements and an increase in the megakaryocytes. Metastatic malignancy from a breast adenocarcinoma was also found in the bone marrow.

Two different clinical and hematologic features are presented by these patients. The first is an example of severe angina with symptoms from a severe ulcerative tonsillo-pharyngitis, and peritonsillar abscess associated with severe granulocytopenia. Eosinophilia was not presented. The blood smear, during the marked neutropenia showed a right shift in the segmented neutro-

phils. The immature and stab neutrophils increased as the white count rose during the recovery phase.

The second patient had methimazole granulocytopenia with marked systemic symptoms, e.g. fever and skin manifestation. The blood and bone marrow eosinophilia in this case apparently has not been previously reported. Apparently methimazole must act on other systems in addition to the haematopoietic system since the symptoms in this patient were out of proportion to the degree of neutropenia. Unlike previous reports<sup>4,5</sup>, liver function tests were normal.

A discussion of the mechanism of granulocytopenia is beyond the scope of this presentation<sup>9</sup>. Maturation arrest with decrease cellular production is suggested however, by the shift to the right of the few circulating granulocytes, a shift to the left and hyperplasia of the granulocytic elements in the marrow.

Toxicity resulting from methimazole therapy may affect any system. Therefore, the patient should be observed clinically and hematologically. Leukopenia and neutropenia may suddenly or gradually occur and may not be detected by frequent differential and white blood cell counts. However, white counts 3,000/cmm. or lower require bone marrow examination to determine continuation of therapy. Therapy may be continued with caution if the marrow is hypercellular or normal cellularity. When there is any evidence of marrow suppression therapy should be discontinued since prognosis with this type of finding is poor. Differential blood counts are necessary to determine the presence of neutropenia, changes in granulocytic maturation spectrum, or eosinophilia.

#### SUMMARY AND CONCLUSIONS

1. Two patients with haematologic manifestations from methimazole toxicity are presented.
2. Methimazole therapy may produce agranulocytosis with oral or systemic manifestations.
3. Frequent white blood cell counts with differentials are recommended on all patients receiving anti-thyroid agents.
4. The presence of a leukopenia of 3000 cells per cubic millimeter or lower with a decrease granulocytic elements, warrants a

bone marrow study to determine the continuation of therapy.  
1853 W. Polk Street.

# DISCUSSION

Dr. J. C. Thomas Rogers, Urbana: May I ask how many of the men here have explored an abdomen for bleeding and not found it? (Eight hands were raised). Well, those are the cases that we would hope that Dr. Whittaker would tell us how to find, because once in a while we come in contact with that type of case and wish for help.

I would like to ask Dr. Whittaker if he has had any cases in which a blood dyscrasia was the cause of bleeding. I ask this because I had a case of multiple myeloma in which I found no source of bleeding on two explorations. At autopsy it proved to be a multiple myeloma. In many of these cases leukemia is a feature, and that certainly explains it.

Dr. Lorin D. Whitaker, Peoria, Ill. I have seen one or two cases in which a blood dyscrasia was the cause of bleeding but I did not have an active part in making the diagnosis. Those cases which were presented here were those in which there was major intestinal bleeding.

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## EDITORIALS



### DO WE KNOW THE ANSWER?

Our tobacco-cancer scientists made the faux pas of the year when they reported on the ill effects of smoking, then allowed themselves to be photographed while puffing away on a pipe. Specific reference is made to the report by Doctors E. Cuyler Hammond and Daniel Horn, director and assistant director, statistical research, of the American Cancer Society. Hammond and Horn admitted their report was premature but felt the statistics were so overwhelming against tobacco that the medical profession should know about it.

The study included interviews with 187,766 healthy men between the ages of 50 and 70, and checking the death certificates of 4,854 of this group who since have died. Deaths from coronary thrombosis and cancer among smokers of a pack or more of cigarettes daily were double those of nonsmokers. Pipe and cigar users escaped this fate, which may explain why the statistical researchers had their pictures taken with their pipes. Despite this observation, we believe the report might have carried more weight and less criticism had the pipes been omitted.

We are an enviable profession yet every day we allow little things to lower our position in the eyes of the public. Most patients take advice seriously but are confused when we fail to prac-

tice what we preach. "Do as I say and not as I do" is a standard joke between physician and some of his understanding patients. But the situation is different when this concept is plastered on the front pages of newspapers for millions to digest.

The effect of tobacco on the body is being studied extensively in laboratories and the subject is being aired thoroughly in newspapers and magazines. It is too bad that most of this work gets into print because the maze of conflicting statistics, the hedging, and double talk confuse the public. Medicine is an exacting science and we hate to see Koch's postulates replaced by circumstantial evidence obtained through statistics. We should stress the fact that we do not know the cause of lung cancer.

We can concentrate on what is known about tobacco. It irritates the respiratory tract, causing bronchitis, and aggravates existing colds. Heavy smokers fare worse than light smokers. Hence we can advise moderation to solve this problem. Cancer of the lung is increasing and therefore the public should be acquainted with early symptoms (cough, hemoptysis, and chest pain); and periodic chest X-rays ought to be recommended. Furthermore, cancer of the lung is easy to diagnose and is an operable lesion.

We know also that nicotine affects the entire cardiovascular system. Individuals with thromboangiitis obliterans should not smoke and the same goes for those with hypertension, coronary thrombosis, angina pectoris, or arrhythmia of the heart, when tobacco aggravates these conditions. Physicians also agree that smoking never improves health nor does it do anyone any good. The exception is that smoking discourages appetite and it is here that we must admit that more persons die from eating too much than are killed from inhaling tobacco.

## THE POSTGRADUATE PROGRAM

The Postgraduate Education Committee, now headed by Louis R. Limarzi of Chicago, is already planning its work for the 1954-5 fiscal year.

The committee asks for the cooperation of all the officers and members of the Illinois State Medical Society to make this an even more successful year than the 1953-4 program.

It is hoped to present at least one, maybe two, major programs in each of the ten districts outside of Cook County. A number of small conferences will also be given and probably the program of one-man clinical hospital demonstrations, presenting patients carefully selected by the local men for teaching value, will be continued.

Good cooperation among councilors, committee members, of whom there is one from each district, and officers of county societies, will make this ambitious project successful.

Letters have been sent to each councilor asking them to consult with committeemen and county secretaries on dates and places. It is hoped that the response will be such as to permit publication of the entire program at an early date.

From that point on, it will be largely the task of the officers of the host county society and its neighbors to get out the attendance. Unless these conferences are well attended, the time, money and energy of the Society in arranging them, the cooperation, experience and devotion of the teachers who give one, sometimes two, days of travel to present them — all these are wasted.

Each host secretary might well give thought to obtaining cooperation from neighboring so-

cieties and to naming as many of his own members as possible to arrangements committees as a method of arousing interest and insuring collaboration. All neighboring secretaries are alerted as soon as time and place are known and each member of the societies involved has two mailed notices, so there is no room for the plea of ignorance. Only good attendance makes these conferences worth the effort.

## LEE T. HOYT, M.D.

November 25, 1895—June 16, 1954

Lee T. Hoyt, the first physician in Illinois to be elected as the "Outstanding General Practitioner" for the year (1948), died at his home in Roseville on Wednesday morning, June 16, 1954. He had been ill for over a year, and had retired from practice.

In 1948 the Illinois State Medical Society presented Doctor Hoyt the award as outstanding general practitioner in the state, and submitted his name to the American Medical Association for consideration as a candidate for the national honor. Roseville community honored him with a banquet and representatives of Warren County Medical Society and the Illinois State Medical Society attended.

He spent much of his life trying to increase the nutritional value of foods through soil fertilization, and his farm near Dallas City afforded him an opportunity to put many of his theories and principles into practice. He acted as the chairman of the Illinois State Medical Society Committee on Nutrition until his health forced his resignation. For the last several years he served the committee in an advisory capacity.

Lee T. Hoyt was born at Good Hope November 25, 1895. He married Miss Bessie H. Jones of Swan Creek in 1920. Doctor Hoyt attended the University of Chicago, took his medical degree at Rush Medical College in Chicago in 1920. He served in internship at West Suburban Hospital in Oak Park, and in the spring of 1921 opened his office at Raritan. Doctor Hoyt practiced at Raritan until 1928, when he moved to Roseville. Associated with him in his Roseville office were two young physicians, his son, Dr. John L. Hoyt, and Dr. Richard Icenogle.

Doctor Hoyt is survived by his wife and two sons, Dr. John L. Hoyt of Roseville, and Dr.

Robert L. Hoyt of Watseka and five grandchildren. His brother Guy Hoyt, who also survives, is assistant superintendent of schools in Los Angeles, California.

Doctor Hoyt was a member of the Warren County Medical Society, the Illinois State Medical Society and the American Medical Association. He was a member of the Monmouth Hospital Staff, and on the courtesy staffs of St. Francis Hospital in Macomb; Mercy and Burlington Hospitals in Burlington, Iowa. He also held membership in the Monmouth Medical Club, the Mississippi Valley Medical Association, and the Friends of the Land (a national soil conservation group).

Doctor Hoyt had served as president of the Warren County Tuberculosis Association; president of the Warren County Chapter of the National Foundation for Infantile Paralysis; he was a Major in the Sixth Infantry Regiment of the Illinois Reserve Militia; a member of the Roseville Booster Club; a director in the Raritan State Bank; a member of the Masonic Lodge and of the Roseville Christian Church.

Doctor Hoyt was always active in civic affairs; he participated in all medical meetings in his county; attended sessions of the Illinois State Medical Society and of the American Medical Association whenever he was able.

Funeral services were held on June 18 at the Roseville Methodist Church with burial in the Roseville Cemetery.

## MAJOR CAUSES OF DEATH IN ILLINOIS

Three causes of death — diseases of the heart, cancer, and vascular lesions affecting the central nervous system — accounted for two thirds of all mortality recorded in Illinois in 1953, according to provisional statistics released recently by the State Department of Public Health.

Topping the list was heart disease, which accounted for 40,424 fatalities, or more than 40 per cent of the 95,407 deaths reported in the State last year for all causes combined.

As in recent years cancer, with 14,947 deaths, was in second place, while vascular lesions ranked third, being responsible for 10,085 fatalities. Other major causes, in order of their frequency, include: accidents, with 5,130 deaths; influenza and pneumonia, 3,396; certain diseases of early

infancy, 3,189; general arteriosclerosis, 1,623; nephritis, 1,542; diabetes, 1,505; and tuberculosis, 1,244.

The ten leading causes of death in the State in 1953 were the same as those which claimed the most lives in 1952. Last year, mortality from all but three causes — heart disease, vascular lesions, and pneumonia and influenza — was as low or lower than the 1952 totals.

Particularly noteworthy is the reduction in tuberculosis mortality, which declined from 1,570 deaths in 1952 to 1,244 in 1953. This new low record brings into tenth place as a cause of death a disease which ranked at the head of the list a half century ago.

With the exception of pneumonia and influenza, all other major communicable diseases were responsible for fewer deaths in 1953 than in the previous twelve-month period.

A 58 per cent reduction was recorded in poliomyelitis, from 249 deaths in 1952 to 103 last year. Similarly, syphilis declined markedly, from 324 deaths to 227, while meningitis dropped from 79 to 61.

As for the more common communicable diseases of childhood, measles declined in mortality from 24 deaths in 1952 to 21 last year, whooping cough from 6 to 4, and diphtheria from 2 to 1.

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## POLIO VACCINE TRIAL NEEDS PHYSICIANS' AID AS IT MOVES INTO EVALUATION PHASE

More than 600,000 children have completed three inoculations, in the field test of the trial polio vaccine developed by Dr. Jonas E. Salk of the University of Pittsburgh. The emphasis now shifts to the evaluation study under the direction of Dr. Thomas Francis, Jr., University of Michigan School of Public Health. The validity of the evaluation is dependent upon data gathered on poliomyelitis cases in the test groups, *including those children in the first three grades who did not get vaccine.*

In addition, data on cases among family members of participating children are an integral part of the study. Since the number of poliomyelitis cases among the test groups may not be large, it is essential that all cases are completely reported. Early diagnosis, prompt re-

porting and follow-up, and the securing of *necessary epidemiological information and laboratory specimens* are important factors in the evaluation.

An outline of procedures and copies of necessary forms have been sent to local and state health authorities. It is important that physicians in areas where vaccinations were not given, cooperate in the study by notifying local or state

health officers of cases occurring among children who participated in the trials and then migrated to another area and children who go to summer camps. Local health officials also need information on participating children who receive injections of gamma globulin.

This phase of the study will depend, to a large degree, on the wholehearted cooperation of practicing physicians.

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## NON SPECIFIC URETHRITIS

Chronic urethritis of nonspecific origin (in women) is a common and troublesome condition. Symptoms are painful urination during the act or at its termination and a variable degree of urinary frequency with the sensation, on occasion, of persistent moisture at the urethral meatus. Symptoms may be protean and any symptoms without explanation occurring between the perineum and umbilicus must be regarded as potentially of urethral origin. The history of these patients is characteristically negative with no previous illness or disability and the general health excellent except for the recurrent episodes of urethral discomfort. Nervousness is to be expected and is the result rather than the cause. Diagnosis is established by finding the bladder and upper urinary tract free of pathology and observing the presence of chronic inflammatory lesions in the urethra. At the time of attempted cystoscopic examination there may be found urethral narrowing. These strictured areas usually are of spastic origin and require gentle dilatation before instrumentation.

Treatment of this condition is trying to both patient and doctor and severely tests the patient's confidence. Urethral dilatation, executed with extreme gentleness to afford drainage of the infected urethral glands, is fundamental therapy. The granular or polypoid areas in the

urethra are best destroyed by mild fulguration under general anesthesia. The urethra may thereafter be chemically cauterized with 5 to 10 per cent silver nitrate through the Kelly endoscope, taking particular care, in applying the proximal urethra, not to permit the silver solution to run down upon the trigone and thus cause chemical trigonitis and greatly increase the patient's discomfort. The instillation of cod liver oil (1 ounce) into the bladder by injection through the urethra is soothing. (Cod liver oil is self-sterilizing.) Local therapy is fortified by such medication as sandalwood oil, antispasmodics, and sedation.

Rest is essential for these patients and activity of great nervous or mental strain is to be strictly avoided. Hot sitz baths often are useful during acute, symptomatic episodes. Diet, except in specific allergies, is not significant although carbonated drinks, spices, and condiments often accentuate symptoms. Symptoms of urethritis often are seemingly endless with or without intermittent interruptions by asymptomatic periods. The patient and doctor may question the utility of their efforts. Certainly persistence is the only solution and the doctor is obliged to encourage the patient who understandably finds her malady an unreasonable burden which affords little external evidence of its agonizing proportions. *Robert Lich, Jr., M.D., The Urethra Of Woman. J. Kentucky M.A. Oct. 1953.*

# MEDICAL ECONOMICS

**The Medical Economics Committee. John R. Wolff, Chairman, Walter C. Bornemeier, Edward W. Cannady, Roland R. Cross, Jr., E. F. Dietrich, W. W. Fullerton, Edwin F. Hirsch, Frederic T. Jung, W. R. Malony, Caesar Portes, William Requarth, Frederick W. Slobe.**



## The Board of Health and Its Relation to the Hospital in the Responsibility for Patient Care

**Robert P. MacFate, Ph.D.**

**Chief of Division of Laboratories, Chicago Board of Health**

Most cities have ordinances which govern the licensing and conduct of hospitals. Details of these ordinances vary, but they all are similar in function and intent, that is, to insure proper care for the citizens who find it necessary to use the services of a hospital.

Chapter 137 of the Chicago Municipal Code, relating to hospitals, reads in part: The Board of Health, upon the presentation of an application for a hospital license, shall make inquiry to ascertain whether such hospital is so conducted as to afford proper accommodations for the care of persons received therein, and that the board of physicians and surgeons give such attendance therein, as will render him or them responsible professionally for the medical and surgical treatment given to any and all patients.

In other words, the Board of Health, by law, is directly responsible for the quality of care given the patient. In conformity with the ordinances and regulations of the municipality which

it serves, the Board of Health must examine each hospital which applies for a license, to determine that those in charge are capable of administering the affairs of the hospital, and that the staff will render proper patient care.

To the hospital administration, the representative of the Board of Health, making an examination of the hospital, may at times appear to be hypercritical and too meticulous. Please be assured, however, that the Board of Health desires to work in full cooperation with the hospital authorities and to be of assistance whenever possible. It is necessary, in conformity with the ordinances and regulations, that each hospital be made aware of its shortcomings in essential services, and must secure correction of any deficiencies before a license is issued. Each hospital must have well defined rules and policies, and the hospital administrators must see to it that these regulations are followed. In turn, these rules and policies must conform to

the city ordinances and must follow well established practices for the benefit of the patient.

It is not the function of the Board of Health to practice medicine. The position of the president of the Board of Health is like that of the baseball umpire. The umpire does not tell the baseball team how they are to play, but he does say, "Whatever you do, it must conform to the rules and regulations."

Few hospital authorities have time to study the detailed procedures of their own hospital staff, in relationship to the practices of other hospital staffs. They may not be aware that outmoded methods are still being pursued in their own hospital, and that other hospitals have discarded these practices for newer and more efficient procedures. Here the Board of Health may be of assistance. Information gathered from many hospitals can be classified and made available to all, thus calling to the attention of hospital administrators and chiefs of staff those procedures and techniques which are not in conformity with the rules, regulations and ordinances.

A well conducted hospital must have clearly defined policies. In addition, the responsible officer or officers must see to it that all of these rules are lived up to at all times, by everyone using the facilities of the hospital. Further, the Board of Health, in its examination of the hospital, must receive more than just verbal assurance that the hospital staff is complying with these rules and regulations. This information can best be obtained by a review of the case records of the hospital. From these records, the chief of staff of the hospital, or the head of a particular department, can best determine just what procedures are being pursued by the general hospital staff, and the Board of Health can determine that the patients receive proper care.

The collection of this information, however, is predicated on the assumption that the hospital records are accurate and complete. Many hospital records so lack details that little, if any, real information can be obtained from them. In some cases it is impossible to determine whether or not the rules and regulations of the hospital are being followed, or the ordinances of the city conformed to.

I could quote many examples of grossly inaccurate records. Perhaps one instance will suf-

fice. A few days ago, and this is a relatively frequent occurrence, we received a birth certificate detailing the birth of a male child. Twenty-four hours later, the death certificate of the same child was received. But sometime during the short life of that child an amazing metamorphosis had taken place, for the death certificate stated that a female had died.

A hospital record is like a will in that, many times, it will be read and an attempt made to interpret the statements therein, when the original writer is not present. Each statement in the record, therefore, should be written with the thought in mind — can someone else, not familiar with this case, read this statement and know exactly what the writer meant to say.

Much time and money is spent in the preparation of records. With more care and attention, these records will yield a wealth of information, well worth the added effort. Further, it is axiomatic that the necessary information to be included in each medical record is essential and important to efficient hospital operation. Complete, accurate records must be available, so that the degree of compliance with all ordinances of the city, and policies of the hospital, may be audited and quickly corrected if found to be faulty.

Records should be kept up to date, so that all available information will be ready at a moment's notice. I quote further from the Chicago Municipal Code: "Every hospital shall keep a complete record of all patients admitted —." Other details are given, and the paragraph ends: "Such records shall be open at all times to the inspection of the Board of Health or its duly authorized representatives." The responsibility of the Board of Health is clearly indicated.

In a recent review of the records of a certain hospital, an amazing percentage of correct "diagnoses proved at autopsy" was found. It was later discovered that the clinical diagnosis was not entered in the record at the time of death but was held in abeyance until the autopsy had been performed.

It is the responsibility of those in authority to see that records are clear, concise and meaningful. Entries should show the date, time and the signature of the person making the entry. This is a "must" for the protection of the hos-

pital, since with this procedure a certain amount of administrative control will be obtained over the various activities within the hospital and the staff members performing them. In turn, this will result in better and more efficient patient care.

The Board of Health wishes to be helpful in every way possible. The public health physician must become more cognizant of the problems facing the hospital staff. The hospital staff must become oriented and aware of their public health responsibilities. By such a team approach, the Board of Health and the hospital staffs can go far in improving patient care.

#### COMMENT

This report was presented before the medi-

cal staff section of the Tri-State Hospital Assembly at Chicago, May 3, 1954. It is an accurate expression of the activities of the Chicago Board of Health in its relationship to the practice of medicine within a licensed hospital.

Since the activities of this board of health may set a pattern for others throughout the state, your committee thought it wise to bring this paper to the attention of all Illinois doctors. We present this report of a high official of the Chicago Board of Health for your information and your discussion. We do this without making any attempt to signify either approval, censure, or criticism.

We should like to remind physicians that Illinois recently enacted a law to license all hospitals in the state.

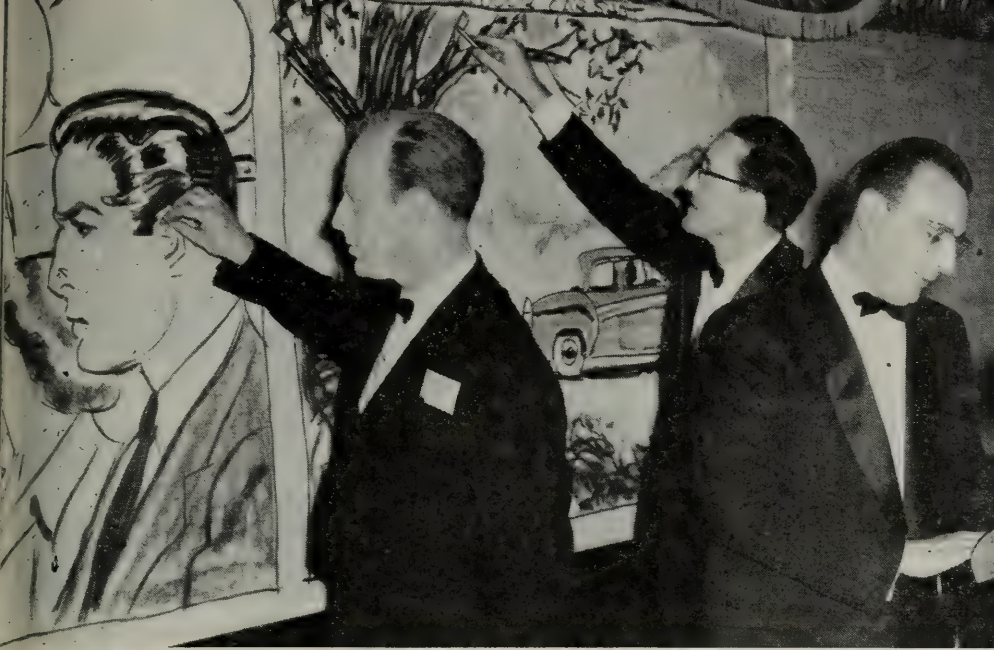
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## NURSING EDUCATION

The pendulum has swung from formal classroom teaching to more teaching on the wards close to patients. The arrangement of subject matter places more emphasis on the patient. This necessitates the concentration of specified subject matter from a number of disciplines rather than a more limited view of nursing care. Nurse educators plan to include the total aspects with which the nurse may be confronted, e. g. dietetic, nursing, social, psychiatric, and public health. Other emerging needs for the student nurse are learning to work in a team and developing leadership characteristics, as well as those skills which make the professional nurse socially acceptable and a safe practitioner. The environment in which the student learns to nurse also

is changing. Even "bedside" nursing is no longer adequate because early ambulation has permitted the patient to care for himself more quickly. "Patient-centered" learning experiences are considered essential. Of late, even this is taking second place, allowing a "people-centered" concept to predominate. Where once the climate was created wholly by the student and professional personnel, it now depends also upon practical nurses, nursing aides, and clerks. Usually these are referred to as members of the nursing team, or more aptly as nursing personnel who, as a group, care for patients. Another team referred to earlier is that of the doctor, dietitian, nurse, and social worker. They also contribute to the teaching of the student. *Lucy D. Germain, Dietetic Aspects Of Nursing Care. J. Am. Dietet. A., Sept. 1953.*

# PICTURE REPORT ON THE 1954 ANNUAL MEETING



Dr. Nicholas P. Dallis (Toledo, Ohio), provided an unusual entertainment at the annual dinner. He is creator of the comic strip "Rex Morgan, M.D.", and this was the first time that he and his assistants produced one before an assembly of doctors. Marvin Bradley (Barrington) and Frank Edginton (Toledo) drew the huge picture while Dr. Dallis was talking.



After his induction, our new President invited his son and wife to the stand to meet the House of Delegates. Joseph Vaughn is studying medicine in Dublin, Ireland, and flew home for the occasion.



Since F. Garm Norbury is so well known to all our readers, it is difficult to tell you something new about him. Let us just say that he is our President-elect.

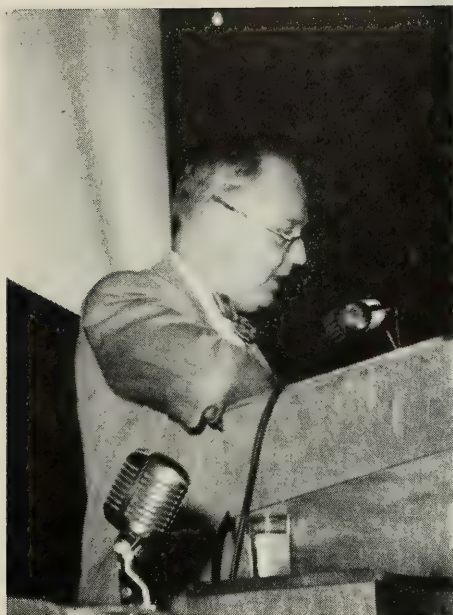


Earl Blair of Chicago is the only new member of the Council. He has been active in civil defense and in particular has been an advocate of the responsibility of the medical profession.



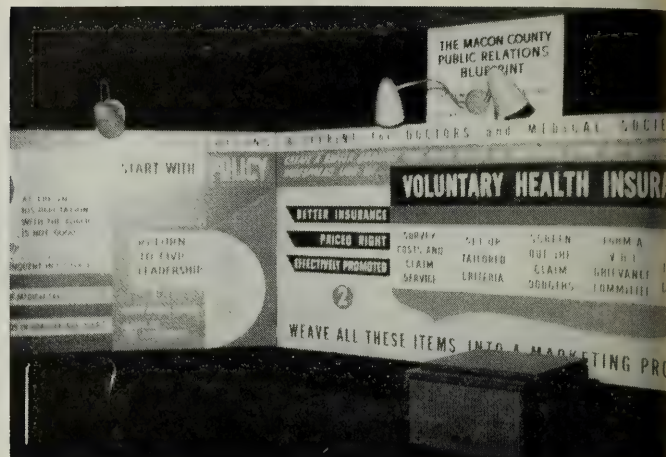
First Vice President Louis R. Lamarzi of Chicago and Second Vice President J. C. Redington of Galesburg are pictured discussing problems common to both of them.





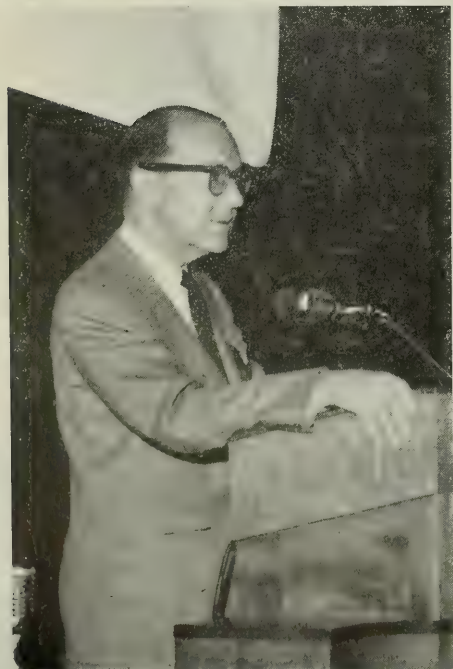
The oration in surgery was delivered by J. Dewey Bisgare, Professor of Surgery, University of Nebraska, College of Medicine, Omaha, Nebraska. His subject was "Cancer-Ulcer Problems of the Stomach."

Exhibits were held under the direction of Dr. Coye Mason. Probably the most graphic was that of Macon County Society, under the direction of Dr. C. Elliott Bell, called a "Blue Print for Public Relations."

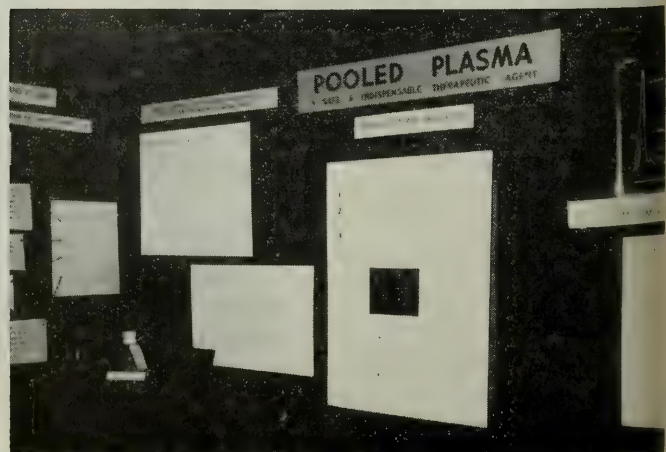


Alton Ochsner, Director of Ochsner Clinic, Professor and Head of the Department of Surgery, Tulane University, School of Medicine, New Orleans, Louisiana, drew a stand-up crowd for his talk on "Cancer of the Lung".

Mrs. Henry Christianen, President of the Woman's Auxiliary, is pictured giving advice to her successor, Mrs. A. T. Kwedar. The Auxiliary has made great progress, and Mrs. Kwedar, who is from Springfield, has promised to continue the good work.



H. Marvin Polard, Associate Professor of Medicine, University of Michigan, University Hospital, Ann Arbor, Michigan, delivered the Oration on Medicine, his title was "Hemorrhage From The Upper Intestinal Tract".



Scientific exhibits were not photogenic. This won a gold medal. Titled "Plasma Without Jaundice" it was the work of J. Garrott Allen, Daniel N. Everson, Carolyn Sykes, Morris Levine and Louis Head.

# THE P.R. PAGE



## Duties During Doldrums

Most of the major activities of professional groups go into a state of suspended animation during the summer doldrums, what with heat, humidity, vacations and general listlessness.

At the risk of disturbing estival equanimity, however, it should be pointed out that now is a good time for planning and organization.

Our thinking should be directed at (1) the elections in November for General Assembly and Congress; and (2) the biennial session of the General Assembly beginning in January.

As corporations, of course, no medical society can devote any part of its own funds to the support or defeat of any political candidate, but every physician is in duty bound, both as physician and citizen, to take an individual interest in political activity. He can, for instance, form or join a political action committee — and he should.

Individually, or as a member of such a committee, he is free to investigate the records and backgrounds, the reputation and personality of any candidate and to decide on that basis whom to support and whom to oppose.

Such committees can also raise funds to give concrete expression to the common opinion, by any proper means, such as campaign contributions, paid advertising, posters, buttons, meetings and travel.

As to the General Assembly, there are no re-

strictions on corporations beyond the ordinary bans against dishonest practise and any medical society or individual member is free to utilize whatever persuasiveness is possible to bring legislators around to his way of thinking. Remember the 1st amendment to the Constitution: "Congress shall make no law . . . . . abridging . . . . the right of the people peaceably to assemble and to petition the Government for a redress of grievances."

Physicians are therefore free to take any considered stand on any issue before the Congress or the General Assembly and to endeavor to persuade a majority to accept and vote on that stand.

For now, organization, making contact with key individuals, study of issues and plans, checking of records and personalities, search for allies and ancillary groups with common interests, arousing their interest, collecting data on people and programs — all these can and should be under way.

## Reinsurance Beaten — For Now

The House killed the administration's reinsurance bill H.R. 8356, by voting 238 to 134 to send it back to the Interstate and Foreign Commerce Committee.

The President, however, was reported to have been extremely angry over the congressional action and to have announced that he will con-

tinue to fight for the bill as long as he is in the White House.

The President still wields much power — rightly or wrongly — and it would be a serious mistake for medicine to become complacent over the House action. The issue is sure to rise again as long as the present personnel setup of department heads and assistants remains in power.

Mrs. Hobby and her advisers are no asset to President Eisenhower politically, or as advisors. The men and women around Mrs. Hobby in the Department of Health, Education and Welfare are the same in most offices who moved the Truman administration so far down the Socialist back road. He would be better served to get rid of the whole group and replace them with capitalists.

So far no one has recalled that on April 13, the HEW issued a news release commemorating its first birthday — one year since the Presidential Reorganization Plan No. 1 brought health, education and the welfare mob together and raised them to cabinet status under Mrs. Hobby as secretary. (The move eliminated the naughty words "Federal Security Agency" from the Washington scene, but the curse moved right into the Department of Health, Education and Welfare.)

Mrs. Hobby's one-year victory statement listed "ten significant developments" of her first year in office.

Listed as No. 4 was the development of a bill to establish "a limited reinsurance service to enable private and non-profit voluntary health insurance to serve more people and offer greater protection."

— And then there were nine.

### Some Press Relations Rules

Dr. John H. Garlock, president of the Medical Society of the County of New York, recently outlined five "basic concepts" to guide physicians in relations with the press. They can be summarized thus, as a basis for discussion:

1. Let the request for an article or statement arise with the editor — not at the doctor's suggestion.
2. Use only one hospital or teaching title, as an identification, not a buildup.
3. Write or talk only on subjects of which you have special knowledge.
4. Press versions of papers given before recognized professional groups are legitimate and proper.
5. Avoid photographs if possible; when in doubt, consult your society.

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## VITAMINS AND STRESS

Too little is actually well established regarding the vitamin requirements of patients during stress. We know that after severe burns, the amount of ascorbic acid which must be administered to produce an increase in ascorbic acid output is very great indeed, of the order of 1,000 to 2,000 mg. per day. Furthermore, the ascorbic acid content of the adrenal has been found to be reduced. It is common practice, therefore, to give patients with burns very large amounts of ascorbic acid for several days and to continue with fairly large amounts after that. The B vitamins undoubtedly are important in

regulating gastrointestinal function and if, for no other reason, we believe they should be supplied for a period after extensive gastrectomy. Thiamin deficiency is especially apt to develop during fever and hyperthyroidism. During thyroid storm it is believed that the requirement may go up at least fourfold. Riboflavin is apparently deposited in the body during periods of protein synthesis and excreted during periods of protein breakdown. Therefore, it may be high in the blood stream at a time of negative nitrogen balance and vice versa. *Jonathan E. Rhoads, M.D., Supranormal Dietary Requirements Of Acutely Ill Patients. J. Am. Dietet. A. Sept. 1953.*

# CORRESPONDENCE



## CLINICS FOR CRIPPLED CHILDREN LISTED FOR SEPTEMBER

Twenty four clinics for Illinois' physically handicapped children have been scheduled for September by the University of Illinois Division of Services for Crippled Children. The Division will count 18 general clinics providing diagnostic orthopedic, pediatric, speech and hearing examinations along with medical social and nursing services. There will be 4 special clinics for children with rheumatic fever and 2 for cerebral palsied children.

Clinics are held by the Division in cooperation with local medical and health organizations, both public and private. Clinicians are selected among private physicians who are certified Board members. Any private physician may refer to or bring to a convenient clinic any child or children for whom he may want examination or may want to receive consultative services.

The September clinics are:

September 1 — Alton, Alton Memorial Hospital

September 1 — Hinsdale, Hinsdale Sanitarium

September 1 — Rock Island (Cerebral Palsy), Foss Home, 3808 — 8th Ave.

September 8 — Joliet, Will County T.B. Sanitarium

September 9 — Clinton, Christian Church  
September 9 — Elmhurst (Rheumatic Fever), Memorial Hospital of DuPage County

September 9 — Springfield, St. John's Hospital

September 10 — Chicago Heights (Rheumatic Fever), St. James Hospital

September 14 — East St. Louis, St. Mary's Hospital

September 14 — Peoria, St. Francis Children's Hospital

September 15 — Evergreen Park, Little Company of Mary Hospital

September 15 — Jacksonville, Our Saviour's Hospital

September 16 — Anna, New City Hospital

September 16 — Rosiclare, Y.M.C.A. Building

September 17 — Evanston, St. Francis Hospital

September 21 — Centralia, Recreation Center

September 22 — Aurora, Copley Memorial Hospital

September 22 — Springfield (Cerebral Palsy), Memorial Hospital

September 23 — Bloomington, St. Joseph's Hospital

September 23 — Chester, Lutheran School

September 23 — Rockford, St. Anthony's Hospital

September 24 — Chicago Heights (Rheumatic Fever), St. James Hospital

September 28 — Effingham (Rheumatic Fever), St. Anthony's Memorial Hospital

September 28 — Peoria, St. Francis Children's Hospital

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## **AMERICAN BOARD OF OBSTETRICS AND GYNECOLOGY**

Applications for certification (American Board of Obstetrics and Gynecology) for the 1955 Part I Examinations are now being accepted. Candidates are urged to make such application sometime in August.

All candidates for admission to the Examinations are required to submit with their application, a plain typewritten list of all patients admitted to the hospitals where they practice, for the year preceding their application or the year prior to their request for reopening of their application, with the diagnosis, pathological diagnosis, nature of treatment, and end result.

Application for examination or re-examination, as well as requests for resubmission of case abstracts, must be made to the Secretary prior to October 1, 1954.

Under a change of requirements for the Part I Examination, candidates must submit 20 case abstracts rather than 25 as formerly. Five of these may be from one's residency service.

Office of the Secretary — Robert L. Faulkner, M.D., 2105 Adelbert Road, Cleveland 6, Ohio

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## **AMERICAN CONGRESS OF PHYSICAL MEDICINE AND REHABILITATION**

The 32nd annual scientific and clinical session of the American Congress of Physical Medicine and Rehabilitation will be held September 6-11, 1954 inclusive, at the Hotel Statler, Washington, D. C.

Scientific and clinical sessions will be given September 7, 8, 9, 10 and 11. All sessions will be open to members of the medical profession in good standing with the American Medical Association.

In addition to the scientific sessions, annual instruction seminars will be held. These lectures will be open to physicians as well as to therapists, who are registered with the American

Registry of Physical Therapists or the American Occupational Therapy Association.

Full information may be obtained by writing to the executive offices, American Congress of Physical Medicine and Rehabilitation, 30 North Michigan Avenue, Chicago 2, Illinois.

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## **CHICAGO GYNECOLOGY SOCIETY OFFICERS**

At the annual meeting of the Chicago Gynecological Society held June 18, 1954, the following officers were elected:

President: J. P. Greenhill, M.D.; President-Elect: Magnus P. Urnes, M.D.; Vice-President: Michael L. Leventhal, M.D.; Secretary: Clyde J. Geiger, M.D.; Treasurer: Robert A. Beebe, M.D.; Pathologist: Ben Miller Peckham, M.D.; Editor: Robert J. Hawkins, M.D.

The address of the new Secretary is 4753 Broadway, Chicago 40, Illinois.

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## **HEKTOEN INSTITUTE RECEIVES GRANTS**

The Hektoen Institute for Medical Research wishes to announce receipt of the following grants: \$10,000 from the Otho S. A. Sprague Memorial Institute, for the salaries of a pediatric cardiologist and a cardiovascular physiologist, involving research of congenital heart disease and acquired valvular disease, under the direction of Dr. Egbert H. Fell and Dr. B. M. Gasul and associates. From the Chicago Heart Association, a grant-in-aid of \$7,560.00 for research studies on congenital and acquired heart disease in infants and children, under the direction of Dr. B. M. Gasul and associates.

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## **CHEST PHYSICIANS POST GRADUATE COURSES**

The Council on Postgraduate Medical Education of the American College of Chest Physicians, in cooperation with the respective state chapters of the College as well as the staffs and faculties of the local hospitals and medical schools, will sponsor the Ninth Annual Postgraduate Course on Diseases of the Chest at the Hotel Knickerbocker, Chicago, Illinois, October 18-22, 1954, and the Seventh Annual Postgraduate Course on Diseases of the Chest to be held at the Hotel New Yorker, New York City, November 8-12, 1954.

These annual postgraduate courses endeavor

to bring physicians up to date on recent advancements in the diagnosis and treatment of heart and lung diseases. Tuition for each course is \$75.

Further information may be secured by writing to the Executive Director, American College of Chest Physicians, 112 East Chestnut Street, Chicago 11, Illinois.

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### **CALEB FISKE MEDICAL ESSAY CONTEST**

The Trustees of what is considered America's oldest medical essay competition, the Caleb Fiske Prize of the Rhode Island Medical Society, announce as the subject for this year's dissertation "MODERN DEVELOPMENTS IN ANESTHESIA." The dissertation must be typewritten, double spaced, and should not exceed 10,000 words. A cash prize of \$250 is offered.

For complete information regarding the regulations write to the Secretary, Caleb Fiske Fund, Rhode Island Medical Society, 106 Francis Street, Providence 3, Rhode Island.

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### **UROLOGY AWARD**

The American Urological Association offers an annual award of \$1000 (first prize of \$500, second prize \$300 and third prize \$200) for essays on the result of some clinical or laboratory research in Urology. Competition shall be limited to urologists who have been graduated not more than ten years, and to men in training to become urologists.

The first prize essay will appear on the program of the forthcoming meeting of the American Urological Association, to be held at the Biltmore Hotel, Los Angeles, California, May 16-19, 1955.

For full particulars write the Executive Secretary, William P. Didusch, 1120 North Charles

Street, Baltimore, Maryland. Essays must be in his hands before January 1, 1955.

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### **MISSISSIPPI VALLEY MEDICAL SOCIETY ANNUAL MEETING**

The nineteenth Annual Meeting of the Mississippi Valley Medical Society will be held at The Hotel Sherman, Chicago, on September 22, 23, 24, 1954. Also meeting at the same place and same time, the eleventh Annual Meeting of the American Medical Writers' Association.

Thirty-seven clinicians have been scheduled to appear on the three day program, and there will be scientific and technical exhibits, all at the Hotel Sherman. The Annual Banquet will be presented on Thursday evening, September 23, following which there will be four short talks by Arch Ward, Sports Editor of the Chicago Tribune, the presidents of the Illinois State Medical Society and Missouri State Medical Association, and by the President-Elect of the Iowa State Medical Society.

The meeting of the American Medical Writers' Association, will be held on Friday, September 24, with Jacob E. Reisch, Springfield, the president of this Association, in the chair. In the morning, a symposium and panel discussion has been arranged to discuss "Collegiate Education in Medical Journalism and Writing". In the afternoon there will be a symposium and panel discussion on "Medical Writing". Following the dinner, there will be a presentation of A.M.W.A. Fellowships, and other awards. The final speaker on the evening program will be Jonathan Forman, M.D., Editor of the Ohio State Medical Journal. All members of the Illinois State Medical Society are cordially invited to attend this annual meeting being held this year for the first time in Chicago.

A complete program for both meetings may be procured by writing to the Secretary, Harold Swanberg, M.D., W.C.U. Building, Quincy, Illinois.

# NEWS OF THE STATE



## ADAMS

**Personal.**—Dr. James Henderson was recently elected vice president of the Illinois chapter of the Reserve Officers' Association.—Dr. Hilliard M. Shair was elected to active membership in the Chicago Dermatologic Society.—Dr. Kenneth H. Keeton on July 1 became associated with Dr. Warren F. Pearce, immediate past president of the Illinois Heart Association.—Dr. Hugh S. Espey was elected to fellowship in the American College of Physicians, reelected president of the Adams County Tuberculosis Association and vice president of the Adams County Heart Association. He is also newly appointed chairman of the section on rheumatic fever of the Illinois Heart Association.

## CLINTON

**Society News.**—On June 9 a joint meeting was held by the Clinton County Medical and Dental Societies. Speakers were Drs. Edmund S. Lockhart and John W. Little, both of Decatur, on "Cancer of the Head, Mouth and Neck."

## COOK

**Dr. Piszczek New Head of Cancer Center.**—Dr. Edward A. Piszczek, director of the Suburban Cook County Tuberculosis District, has been elected president of the Cancer Prevention Center, 17 West Huron Street. Five new members were named to the board of directors: Mrs. Lucius Cole, Oak Park; Dr. Frank H. Fowler, president of the Chicago Medical Society; Mrs. Esther Fraser, executive secretary of the society; Dr. Opal Hepler of Passavant Hospital, and Mrs. Wade Reece, immediate past president, Illinois Federation of Women's Clubs.

**Lloyd Gittelson Given New Post at Presbyterian.**—Lloyd A. Gittelson has been appointed chairman

of the department of anesthesiology, at Presbyterian Hospital. The appointment carries a concurrent one of clinical professor (Rush) at the University of Illinois College of Medicine. He succeeds Dr. Mary Lyons, retired.

**Personal.**—Drs. Milan Novak and Ford K. Hick, Chicago, have been appointed as members of the executive committee of the Tuberculosis Institute of Chicago and Cook County. Dr. Novak is associate dean of the University of Illinois Graduate School and Dr. Hick, professor of medicine at the college of medicine.—Drs. Sanford A. Franzblau and Alexander Ruggie announce the removal of their office to 55 East Washington Street, Chicago 2.

**Oliver Wendell Holmes' Bookcases Given to Illinois.**—Dr. and Mrs. Bernard Appel, Lynn, Mass., have given the private bookcases of Dr. Oliver Wendell Holmes to the University of Illinois College of Medicine.

**Special Lectures Honor Famous Physicians.**—The eighth William Allen Pusey Memorial Lecture, sponsored jointly by the Institute of Medicine of Chicago and the Chicago Dermatological Society, will be delivered by Charles C. Curtis, M.D., professor and chairman of the department of dermatology and syphilology, University of Michigan School of Medicine, Ann Arbor, September 22, 1954. Title of the lecture will be "A Study of Some New Drugs Valuable in the Treatment of the Deep Mycoses." This will be a dinner meeting at the Drake Hotel.

The late James B. Herrick will be honored with a memorial meeting, Wednesday, October 13, sponsored by the Society of Medical History of Chicago and the Institute of Medicine of Chicago. This will

be a 6 p.m. dinner meeting at the Western Society of Engineers in the Crerar Library Building. Ernest E. Irons will discuss "Herrick, the Man;" Morris Fishbein, "Herrick as an Historian", and Emmet B. Bay, "Herrick, the Cardiologist."

**New Cornerstone Laid.**—Sterling Morton, chairman of the Morton Salt Company, laid the cornerstone, June 15, for the new \$1,552,000 Morton Medical Research Building at the Northwestern University Medical Center. J. Roscoe Miller, M.D., president of Northwestern University, presided at the ceremonies and speakers included Mayor Martin Kennelly, Richard H. Young, M.D., dean of the medical school, and Kenneth F. Burgess, president of Northwestern's board of trustees.

The seven-story building at 310 East Superior Street will be occupied by research personnel who have carried on their work in laboratories of the Montgomery Ward Memorial Building at 303 East Chicago Avenue. Present plans call for completion in May 1955.

**Forty-Five Million Volt Linear Accelerator Formally Dedicated.**—On June 15, appropriate ceremonies formally marked the dedication of the new 45 million volt linear accelerator at Michael Reese Hospital. This is said to be the first apparatus of its type ever constructed for medical purposes. The basic principle consists of the acceleration of light particles (electrons) on a linear basis rather than in an orbit as in a betatron (for light particles) or a cyclotron (for heavy particles. The linear accelerator of Michael Reese Hospital was constructed on the pattern of the projected one billion volt apparatus developed in the Microwave Laboratory of Stanford University in Palo Alto, Calif., and certain essential parts of this apparatus were procured from Stanford University. Construction and installation of the apparatus were done by Helene Curtis Industries, Inc., in Chicago.

The building, which for protective purposes contains three-foot thick walls of reinforced concrete and houses the machine, a patients' treatment room, control room and laboratory facilities, was constructed during the second half of 1953 at a cost of \$100,000. The entire project cost more than \$300,000.

Experiments with animals are now going forward to study various effects of the beams on diseased tissue. Erich M. Uhlmann, M.D., director of the Tumor Clinic at Michael Reese, is in charge of the project. He is credited with launching experimental studies on free electrons in 1928 with energies of 250,000 volts. He has continuously pursued this problem until its culmination in the liberation of free electron beams in the multi-million volt range.

**Special Society Elections.**—Recently elected officers of the Illinois Psychiatric Society are Drs. Percival Bailey, president; Franz Alexander, vice president; Alex J. Arieff, secretary-treasurer, and H. H. Garner and James G. Miller, councilors, according to Dr. Louis B. Shapiro, the outgoing

secretary-treasurer.—At the annual meeting of the Chicago Gynecological Society, June 18, Dr. Magnus P. Urnes was chosen president elect and Dr. J. P. Greenhill was installed as president. Other officers are Drs. Michael L. Leventhal, vice president; Clyde J. Geiger, secretary; Robert A. Beebe, treasurer; Ben Miller Peckham, pathologist, and Robert J. Hawkins, editor. The address of the new secretary is 4753 Broadway, Chicago 40, Illinois, according to Dr. Edwin J. DeCosta, outgoing secretary.

**Society News.**—Dr. Louis B. Newman, chief of the physical medicine and rehabilitation service, Veterans Administration Research Hospital, Chicago, addressed the Multiple Sclerosis Foundation of America, May 7, at the Spaulding School, Chicago. His subject was "The Role of Physical Medicine and Rehabilitation in Multiple Sclerosis."

### MADISON

**Society Enjoys Hospitality of Groves Smith.**—The Madison County Medical Society was the guest of Dr. Groves B. Smith, July 2, at a buffet supper at Beverly Farm, Godfrey. Dr. Smith, who is superintendent and medical director of Beverly Farm, entertains the society annually. At the June meeting of the society, Dr. Michael M. Karl, St. Louis, assistant professor of clinical medicine, Washington University School of Medicine, St. Louis, spoke on "Treatment of Liver Insufficiency and Coma."

### MORGAN

**Personal.**—Dr. Frank B. Norbury has been named associate physician on the staff of Norbury Sanatorium and secretary of the corporation. Dr. Norbury, who has been assistant resident in medicine at Barnes Hospital for the past year, was awarded the Bronze Star for work in combat psychiatry, during the Korean war.

### WINNEBAGO

**Personal.**—Dr. Hugh A. Johnson announces the opening of his office in The Gas-Electric Building, Rockford. He will limit his practice to plastic and reconstructive surgery.

**New Format Dresses Up Society's Bulletin.**—The Winnebago County Medical Society is to be congratulated on the format launched with the June issue of its Bulletin. The twenty-three page publication is to be commended for newsworthy interest and easy readability. The contents are presented in a smart, pithy and pertinent style.

### DEATHS

Walter Arthur Bressmer, Blue Mound, who graduated at Northwestern University Medical School in 1915, died April 12, aged 68, of carcinoma of the rectum. He was affiliated with Decatur and Macon Hospital and St. Mary's Hospital in Decatur, and was a member of the Illinois State Medical Society.

Homer Joshua Elkins, Mounds, who graduated at Barnes Medical College, St. Louis, in 1910, died February 18, aged 67, of coronary thrombosis. He was a past president of the Pulaski County Medical Society; for many years county coroner; on the staff of St.

Mary's Hospital in Cairo; district surgeon for the Illinois Central Railroad, and a member of the Illinois State Medical Society.

Raymond Evans, Champaign, who graduated at the Chicago College of Medicine and Surgery in 1915, died in Burnham City Hospital, February 1, aged 65, of cerebral hemorrhage. He was a member of the Illinois State Medical Society.

George Fenyes, Chicago, who graduated at Medizinische Fakultät der Universität, Wien, Germany, in 1927, died June 27, aged 56. He was a member of the Illinois State Medical Society and formerly was on the staffs of Chicago State and Manteno Hospitals.

Alexander I. Froehlich, McHenry, who graduated at Marquette University School of Medicine, Milwaukee, in 1913, died April 17, aged 63. He was a member of the Illinois State Medical Society and for many years a member of the local school board.

William Arthur Frymire, Monmouth, who graduated at the University of Illinois College of Medicine in 1913, died in Monmouth Hospital, April 16, aged 70, of cerebral hemorrhage. He was a member of the Illinois State Medical Society, a past president of the Warren County Medical Society, for many years medical missionary in the Belgian Congo in Africa, and had served as health officer.

John Milton Guy, retired, who graduated at Rush Medical College in 1886, died recently, aged 93.

Frank L. Hubbard, retired, Virginia, who graduated at Rush Medical College in 1901, died May 25, aged 78, of cancer. He was a member of the Illinois State Medical Society and had served in the Navy Medical Corps for 22 years until his retirement in 1939.

Henry Houston, who graduated at Bennett Medical College in 1907, died June 13, aged 87.

Arthur K. Koff, Chicago, who graduated at McGill University Faculty of Medicine, Montreal, Canada, in 1928, died June 28, aged 50. He was a member of the Illinois State Medical Society and on the staffs of Michael Reese and Chicago Lying-In Hospitals.

Sidney O. Levinson, Chicago, who graduated at Washington University School of Medicine, St. Louis, in 1927, died June 20, aged 50. He was a member of the Illinois State Medical Society and executive director of Michael Reese Research Foundation.

Emil Lofgren, retired, Rockford, who graduated at Northwestern University Medical School in 1901, died

March 9, aged 80. He was a member of the Illinois State Medical Society, the Veterans of Foreign Wars, and United Spanish War Veterans.

Clyde S. McAtee, Fox Lake, formerly of Chicago, who graduated at Northwestern University Medical School in 1921, died July 10, aged 63. He served in the army medical corps in World War I.

Joseph G. Parmley, Marion, who graduated at the University of Louisville Medical Department, Kentucky, in 1908, died April 15, aged 77, of arteriosclerosis. He was a member of the Illinois State Medical Society; for 18 years he was secretary and for four years president of the Williamson County Medical Society.

John Henry Phillips, Granite City, who graduated at St. Louis University School of Medicine in 1923, died June 10, aged 59. He was a member of the Illinois State Medical Society and of the staff of St. Elizabeth's Hospital, Granite City.

Mitchell D. Redyk, Chicago, who graduated at Loyola University School of Medicine in 1946, died July 1, aged 36.

Norman Lee Seelye, Harvard, who graduated at the College of Physicians and Surgeons of Chicago, School of Medicine of the University of Illinois, in 1903, died February 19, aged 75. He was a member of the Illinois State Medical Society.

Chester Richard Szalony, Chicago, who graduated at Indiana University School of Medicine, Indianapolis, in 1953, was killed in an automobile accident, March 14, aged 25.

Adolph Maurice Teixler, Belleville, who graduated at the Chicago College of Medicine and Surgery in 1914, died March 12, aged 67, of cerebral thrombosis. He was affiliated with St. Mary's and Christian Welfare Hospitals in East St. Louis.

Leonard Martin Thompson, Lena, who graduated at the Chicago Medical School in 1921, died March 22, aged 59, of carcinoma of the pancreas. He was a member of the Illinois State Medical Society, the International College of Surgeons, and was local surgeon for the Illinois Central Railroad.

Charles Eli Wright, Rockford, who graduated at the College of Physicians and Surgeons of Chicago, School of Medicine of the University of Illinois, in 1901, died February 25, aged 84. He was a member of the Illinois State Medical Society.

# HOUSE OF DELEGATES



## SECOND SESSION

The second session of the House of Delegates of the Illinois State Medical Society was called to order by the President, Willis I. Lewis, at 3:15 P.M., Thursday, May 20, 1954. Harlan English, as Chairman of the Committee on Credentials reported that there were 132 delegates and officers present, the roll had been called and he moved that this constitute the voting strength of this session of the House. Second by W. E. Kittler, and carried.

The President ruled that the attendance slips would constitute the roll call for the session. The Secretary read the minutes of the first session of the House of Delegates, Motion: Pfeiffenberger-Hayes, that same be approved. Motion carried.

The next order of business was the selection of the meeting place for the 1957 annual meeting. Motion: Kittler-C. Paul White, that the House give preference to the Hotel Sherman, Chicago, with final arrangements to be made by the Council. Motion carried. There being no unfinished business, the President called for action upon the list of candidates for Emeritus and Retired membership, approved and submitted by component societies. Motion: Caesar Portes, second by Robert H. Hayes, that same be approved. Motion carried: Hayes, as Chairman of the Committee on Necrology stated that the death of another member had been reported to him, and he urged members knowing of the death of other members not included on the list as printed in the handbook, to notify him.

Oscar Hawkinson presented a resolution prepared by the Medico-Legal and Committee on Medical Testimony, protesting at the delay in hearing of personal injury suits, and urging the Council to appoint a Committee to collaborate with a similar committee from the Bar Association in the exploration and study of some plan by which these suits might be expedited. Doctor

Hawkinson stated that the Chicago Tribune recently in an editorial stated that the Northwestern Quarterly Law Review in an article reported that there were some 30,000 such suits in our courts. It was estimated that it would take at least three years to catch up with this load. Hawkinson moved, second by Frank Fowler, that the House resolve itself into a Committee of the Whole and take action on his resolution. Motion carried, the President asking the Secretary to take the chair. Then, following some discussion of the proposal, the motion again made by Hawkinson, second by Fowler, was put and carried unanimously. (The action then approved by the House.)

The President then asked for reports of Reference Committees, calling first for the report of the Committee on Reports of Officers, Tom Kirkwood, Chairman. Kirkwood presented the reports, first commenting upon the fine work done by the President, Dr. Lewis, during the past year. He had travelled extensively throughout the state, visiting many component societies. He had attended annual meetings of several adjoining state societies thus promoting better interstate society relations and had the opportunity to compare our problems with those of other societies. The Committee was gratified to note the President's statement that he found much less opposition to that portion of the annual dues allocated to the American Medical Education Foundation, and the Committee hopes that other state societies will adopt a similar procedure. The Committee believes that this worthy project should be continued for a few years before deciding upon a future course; every effort should be made to keep medical education under control of the medical profession. Comments were made on the President's remarks on some members of the present administration in Washington showing a tendency to revert to practices which medicine has opposed. Some new policies proposed may sound harmless on the surface, but

contain dangerous possibilities. This is no time for the profession to be lulled into a feeling of complacency and security, and we must remain alert and be ready for action. Comments were made on the President's visit to the Monmouth office, and the Committee congratulated the Secretary and his force for their many services, as mentioned by Doctor Lewis. The Committee was interested in Dr. Lewis' interest in the old records in the Secretary's office, and in order that all members may be aware of medical progress in Illinois, the Committee concurs in the recommendations of Dr. Lewis relative to an early publishing of the second volume of the History of Medicine in Illinois. The Committee praised the efforts of Dr. D. J. Davis, chosen as editor for the volume, and also James H. Hutton, Chairman of the History Committee, for their work in procuring the material for the proposed book. The report of the Chairman of the Council, F. Lee Stone is an indication of the inherent strength of the state medical society. The Committee heartily approves the President's statements pertaining to the work of the Committee on Medical Service and Public Relations, and commends the brochure prepared by James C. Leary for the Committee on the Public Relations Program for county societies. This was favorably commented upon by Dr. Frank E. Wilson, Director of the A. M. A. Washington office at the P & R Dinner meeting on Tuesday evening. The committee thoroughly appreciates the efforts of the Committee on Medical Service and Public Relations, and Mr. Leary for their fine work. Every county society should develop a sound public relations program. Macon and Peoria counties are showing us how to carry on this work, as is also being done in a number of other counties of Illinois. Our president describes the excellent programs arranged by the Post Graduate Committee and the work of the Woman's Auxiliary and its president, Mrs. Henry Christiansen, likewise the fine work done by the Committee on Rural Health, under Harlan English as Chairman. To these activities we most heartily subscribe. Kirkwood moves the adoption of this portion of the report, second by Charles Eck and carried.

The committee has reviewed the report of the President-Elect, Arkell M. Vaughn, concerning his indoctrination period and commends him for so thoroughly preparing himself for his work next year as our president. He has attended many meetings during the past year, including the two meetings of the A. M. A. He is indeed to be congratulated for the fine work he has done and he has undoubtedly prepared himself well for the coming year as our president. We feel quite sure that the Society can look forward with confidence to another successful year under his leadership. Doctor Kirkwood moved the adoption of this portion of the report, second by O. W. Rest, and carried.

Kirkwood comments on the report of the Secretary, finding it comprehensive and complete. Comments were made on the pioneering efforts of the former Editor of the Illinois Medical Journal, Charles J. Whalen, in emphasizing to the danger from the inroads of the government into the field of medical care, and intro-

ducing the first resolution in the A. M. A. House of Delegates urging opposition to this danger. The Committee also approves the Secretary's recommendation that the Annual Society Officers Conference to be held in the interim between annual meetings. The Committee commends the present methods of scheduling meetings of the House of Delegates, and recommends that it be continued until a better method can be found. Most delegates interviewed do not want to come a day or two in advance of the Annual Meeting for meetings of the House. The Committee approves the scheduling on Friday afternoon of the "Kollege of Xperience" which is a novel idea which should be of great value to interns and residents and other young physicians. The Committee commends the Illinois Physicians Placement Service conducted so well under the supervision of Mrs. Jane Swanson in the Secretary's Office, but desires to call to the attention of the county societies of their responsibility in interesting them in the new locations. The Committee is appreciative of the fine service rendered by the Secretary and his clerical force, Frances Zimmer, Jane Swanson, Wanda Ross and Mary Ward. The Chicago office is likewise well staffed and efficient. We are all grateful for the fine spirit of cooperation between the State Health Department and its Director, Dr. Roland Cross, which we believe is conducive to constant improvement in the health of the citizens of this state. An excellent understanding of the work of the Council is available to the delegates who read the report of the Chairman of the Council, as recommended by the Secretary. Dr. Kirkwood moves the adoption of this portion of the report, second by Caesar Portes and carried.

Dr. Kirkwood commends the Committee on Scientific Work for its efforts in arranging the programs for this annual meeting. There is a minimum of conflicts with committee and other meetings. The programs are comprehensive and of more than usual interest. The papers are practical and furnish much valuable information. Most sessions are well attended. The audiences have been very attentive which is a tribute to the caliber and ability of the speakers. The Technical and Scientific Exhibits should be visited by all attending the meeting. Lack of interest in any exhibit may mean its loss at the next meeting. The exhibits are attractive and well planned. The Committee is well satisfied with the arrangements made at the Hotel Sherman. Floor space for exhibits, rooms for general meetings, section meetings and the use of reference committees are ideal for our purposes. The Committee appreciates the cordial relations existing between the hotel management and our society. Dr. Kirkwood moves the adoption of this portion of the report, second by J. Howard Maloney and carried. Dr. Kirkwood moves the adoption of the report as a whole, as signed by the personnel of the committee. Second by W. E. Kittler and carried.

The President recognized Harlan English who had an important emergency matter to present to the House. Dr. English stated that this morning the House Ways and Means Committee in Washington voted 12 to 8 to include physicians in the social security system. Today

a member of the Committee in Washington moved that the committee reconsider their vote of yesterday. He proposed that a telegram be sent immediately to tell members of the committee how physicians in Illinois feel about that subject, and urge that their action of yesterday be reversed. English hopes that immediate action can be taken, and he submits a proposed telegram to be sent to members of the Ways and Means Committee at once. Motion, Percy E. Hopkins, second by Mather Pfeifferberger, that the House resolve itself into a Committee of the Whole, to give immediate consideration to this report. Motion carried. Secretary then moves that this Committee of the Whole approves the sending of these telgrams immediately, as the actions of this Society Second by Frank Fowler, and Mather Pfeifferberger. Several discussed the proposal, W. H. Schowengerdt, E. S. Hamilton, and others. The motion to adopt was put and unanimously carried. By proper action the group arose from the Committee of the Whole. Motion, Warren Furey, second by Frank Fowler, that the House reaffirm the motion as a part of the actions of the House of Delegates. Motion carried.

The Committee on Reports of Councilors, G. Henry Mundt, Chairman was then called for by the President. Doctor Mundt stated that the committee reviewed with satisfaction the report of the Chairman of the Council who gave a fine report of Council actions during the past year. They commend the effort to reduce the number of committee reports as well as shortening them. The Committee regrets the resignation of Doctor Coleman as chairman of the I. P. A. C. Medical Advisory Committee and also chairman of the Advisory Committee to the United Mine Workers Health and Welfare Fund. They commend the reorganization of the Committee on Industrial Health as an important activity. They regret the resignation of Mr. John W. Neal who has invariably done a fine job for the Society. They commend the fine work done by Dr. Hellmuth, as Chairman of the Post Graduate Committee and are sorry to hear that he is leaving Illinois. They appreciate the reference to the honor presented to Earl Blair, and also the work done by the Physicians Placement Service in the Secretary's office. The appointment of Louis R. Limarzi as General Chairman of the Committee on Arrangements for this meeting is appreciated and the wisdom in selecting him is well demonstrated in this meeting. The Committee approves the holding of the Society Officers Conference in Springfield, apart from the Annual Meeting. They commend the Council and its Chairman for the authorization of the second volume of the History of Medicine in Illinois. Dr. Mundt moves the adoption of this portion of the report, second by E. E. Davis, and carried. The Committee comments favorably on the report of the Councilor from the Second District pertaining to schools of nursing in some Illinois hospitals.

It seems desirable to maintain nurses training schools in smaller hospitals when humanly possible. Doctor Mundt moves the adoption of this portion of the report, second by Dr. Pfeifferberger, and carried. Dr. Mundt

approves the report of the Councilors for the third district. Commenting on the report of the Councilor for the Fourth District, Dr. Mundt wonders if other districts can equal the membership in that district, as the Councilor, Dr. Blair, stated that with 564 physicians in the district, all but 23 are members of organized medicine, with a percentage of 96.2% and most of the non-members are aliens, not eligible for membership. Dr. Mundt moves the approval of this portion of the report, second by E. E. Davis, and carried. Dr. Mundt comments upon that portion of the report of the Councilor for the 5th district, referring to the postgraduate conference to which members of the dental and legal professions were invited, at which two presentations were made of general interest to all groups. They were especially interested in the presentation, "Tax and Estate Planning for Professional Men", and recommend that this be published in the Illinois Medical Journal. Dr. Mundt moved that this portion of the report be approved, second by Charles Eck and carried. Reports from the Sixth and Seventh districts were commented upon. The public relations work in Macon County was of unusual interest and should be read in the report, by all members of the House. Dr. Mundt moved the approval of this portion of the report, second by E. S. Hamilton, and carried. Dr. Mundt referred to reports of the Councilors of the other districts, commenting upon some projects reported in them. Referred also to the report of the Councilor at Large, Dr. Sweeney. Mundt moved, second by Charles Eck, that this portion of the report be approved. Motion carried. Dr. Mundt moved the adoption of the report as a whole, second by Robert H. Hayes, and carried.

The President called for the report of the Committee on reports of Standing Committees, C. Paul White, Chairman. Dr. White first commented upon the report of the Committee on Medical Service and Public Relations, as published in the handbook. Dr. Hopkins as chairman and James C. Leary, Director of Public Relations, were both commended for the tremendous amount of activity as shown in the report. It was with some concern that the committee noted the gradual increased cost of operating this Committee and the Educational Committee, although they recognize the importance of this work which must continue. The Committee recommends that the Council makes a careful audit of the services and finances involved with the purpose of reorganization for the matter of efficiency and economy. White moves the adoption of this portion of the report, second by E. E. Davis, and carried. The Committee reviewed the report of the Medico Legal Committee, and listened to discussions by its chairman and others. In recent years there has been but little work for the committee seemingly because insurance companies prefer to handle their insured in their own way. The committee observes with concern the reactions of companies issuing malpractice insurance to certain groups such as radiologists, anesthesiologists, etc., and also the increasing cost to the general practitioner for his coverage. The Reference Committee recommends that the Council select a committee to investigate the ramifications of

this type of insurance, and also consider the possible advisability of discontinuing the Medico Legal Committee, or combining it with the Committee on Medical Testimony. White moved the adoption of this portion of the report, second by E. V. McCarthy and carried.

The report of the Committee on Archives was of unusual interest, and the Committee Chairman, Tom Kirkwood, appeared before them to give additional information. The Committee hopes that the Council will authorize the early publication of the History of Medical Practice from 1850 to 1900. The preview given by Dr. Hutton should create a desire on the part of every member for a copy of the book. White moves the adoption of this portion of the report, second by Charles H. Phifer. Hamilton asked that the report be changed in its paragraph "directing the Council to advance enough money to publish this history". This should be a recommendation rather than a directive to the Council. After some little discussion White agreed to this slight change in the report. The report was therefore amended, and carried, as amended.

White stated that the report of the Committee on Medical Education and Hospitals was of unusual interest to his committee. They were all concerned about the present status of nurses and the gradual decrease in number of nurses training schools in Illinois. The Committee believes that every possible effort should be expended to continue activities of the existing training

White stated that the report of the Committee on schools throughout the state, provide them with ample facilities and encourage more girls to take up this training. The Committee believes that nurses are too often asked to take on responsibilities beyond those which might reasonably be expected of them, and they desire to remind the physicians that these acts are not legal, and the legal responsibility falls upon the shoulders of the physician in charge. The Committee recommends that every delegate read this report carefully, and carry back to his home society the vast amount of information given by Dr. O'Brien the chairman, and his committee. This committee was highly complimented by the Reference Committee. White moves the adoption of this portion of the report, second by William Whiting, and carried.

White stated that the report of the Committee on Medical Benevolence was most interesting, and his committee is filled with pride to know that something has been done to relieve needy practitioners and members of physician's families. They approve the Chairman's recommendation that the Committee be permitted to allocate benefits of \$75.00 per month, instead of \$50.00 as the maximum without Council approval. The Committee was sorry to hear of the recent illness of Dr. Hayes, Chairman, and is glad that he is now able to continue directing the activities of this important committee. White moves the adoption of this portion of the report, second by William Whiting and carried.

The Reference Committee was pleased to note in the report of the Committee on Medical Testimony that there had been only one problem concerning dishonest testimony in our courts, reported to them during the past year. After reviewing this report, the Committee

again believes it may be advisable to combine the functions of the Medico Legal Committee, and the Committee on Medical Testimony. White moves the adoption of this portion of the report, second by E. E. Davis, and carried.

White then reviewed the report of the Grievance Committee, commenting upon actions being taken during the past year by component Society Grievance Committees, with less functions directed to this state society committee. He is glad to note that the interest in these local committees is gradually increasing and they are now functioning well, and it is hoped that more problems can be cared for satisfactorily at the local level, rather than asking the State Society Committee to hold hearings to consider local problems. White moves the adoption of this portion of the report, seconded by William Whiting and carried.

Doctor White then reported on resolutions as referred to his committee. There was some discussion as to whether the entire resolution should be read or merely the "whereas" portions. Motion, Pfeifferberger-Charles P. Blair, that the entire resolution be read, and after further discussion, the motion was approved. White referred to the resolution from the Winnebago County Society relative to the allocation of a portion of the annual dues to the American Medical Education Foundation. He stated that many appeared before the committee to offer testimony at the hearing the previous day. The Committee was anxious to get a free discussion of this problem. Six members of the Winnebago County Society were present, including Dr. Weld who introduced the resolution. The Committee appreciates the sincerity of the Winnebago Society members, but the Committee does not recognize this as an assessment, but rather a part of the annual dues, allocated under Council instructions to this A. M. E. F. In some other state societies, an outright grant is made to the fund each year from the Society treasury. The Committee believes this is no more of a compulsion than the small amount allocated to the Medical Benevolence Fund, or for Medical Service and Public Relations, Educational Committee, or Post Graduate Committee appropriations on the part of the Council as recommended by this House of Delegates. The Reference Committee is unanimous in its opinion and would recommend to the House of Delegates that this resolution be not adopted. White moves the adoption of this report, second by Percy E. Hopkins.

Dr. Weld was first recognized by the President, Dr. Weld outlined four basic points, first, the medical schools of the nation do need financial assistance (2) there is reason to believe that the Federal Government might take over control of these schools by giving them financial help (3) The Illinois plan is a good plan for raising money, because each member contributes to the A. M. E. F. whether he wishes to or not. (4) we do not object to the \$20.00 assessment because of the amount involved; possibly every member could well afford to pay even \$100.00 annually to the fund. Dr. Weld elaborated on these points in his discussion. Frank Fowler, as Chairman of the Council of the Chicago Medical Society, stated that the resolution as presented

by Dr. Weld was thoroughly discussed in his Council, and the vote was unanimously against the resolution. Further discussions by Walter C. Bornemeier, James H. Hutton, and others. The motion was called for, and the resolution was not adopted.

Dr. White presented two resolutions from the St. Clair County Medical Society. The first one, "Foreign trained physicians ineligible for licensure in the United States"; after careful consideration, the Committee does not feel that the resolution would accomplish the purpose for which it was intended. We believe there is merit in the purpose behind the resolution. We, therefore, recommend to this House of Delegates that the resolution be referred to the Committee on Medical Education and Hospitals for further study. White moves the adoption of this report, second by Charles P. Blair. Discussion by Dr. H. J. Nebel, East St. Louis asking for information; if this resolution is referred back to another committee for study, what is going to happen to it? We will wait until next year and in the meantime we will get 200 or 300 more men, why cannot something be done? Further discussion by W. E. Kittler and others. Dr. White said he appreciated the remarks of Dr. Nebel, and also the statements given by Nebel to his committee at its hearing. The Committee believes the resolution has merit, but there are other implications that might defeat its purpose. The Committee believes it best to refer the resolution to the committee connected with hospitals and medical education for additional study, then recommendations.

Dr. Warren W. Furey presented an amendment for consideration of the House which will not change the motion before the House. He moves that after proper study by the Committee on Medical Education and Hospitals it be referred to the Council for immediate action. Second by W. H. Walton. The amendment was approved, and the motion as amended was carried.

The second resolution from the St. Clair County Society referred to the screening of foreign trained physicians by the National Board of Medical Examiners as a prerequisite to consider for licensure. The reference committee disapproves this resolution; they heard members of the Medical Examining Board of the State of Illinois and former members who gave the information that the Illinois Medical Examining Committee screens its applicants at the state level in a manner which we believe is not second to that of the National Board and we believe it should be done at the state level. The reference committee, therefore, recommends that this resolution be not adopted, and White so moves. Second by Harlan English, and carried.

White referred to the resolution from the Jackson County Medical Society as published in the handbook, and relative to requirement of citizenship for license to practice medicine in Illinois. The Committee finds itself in complete accord with the resolution, but would like to add an amendment to the resolution. "Following the last word, United States, we would like to add "or Canada". White moves the adoption of the resolution as amended, second by K. M. Nelson, Princeton. There was considerable discussion on this resolution, and also

the amendment as presented by the Chairman. Dr. White finally was willing to report favorably on the resolution with the deletion of the words "or Canada". The original motion was so changed and carried.

The resolution from the North Shore Branch of the Chicago Medical Society, published in the handbook, and pertaining to allocation of funds to the American Medical Education Foundation by organizations collecting monies from the public for medical education, was then considered. Dr. White stated that his committee is in full accord with the provisions of this resolution, and he moved the adoption of the resolution, second by J. Mather Pfeiffenberger, and carried.

White stated that this report was signed by all members of the Committee and he moved the adoption of the report as a whole, second by Dr. Pfeiffenberger and carried. Motion: Elmer V. McCarthy that the House adjourn until 8:30 A.M. the following day, second by Caesar Portes and carried. The session adjourned at 5:25 P.M. to meet Friday morning at 8:30 A.M.

### THIRD SESSION

The third session of the House of Delegates was called to order by the President, Willis I. Lewis, on Friday, May 21, 1954, at 8:34 A.M. English as Chairman of the Credentials Committee reported a quorum present, the number to be reported later. The first order of business was the report of Coye C. Mason, Director of Scientific Exhibits. The following awards to scientific exhibitors has been approved by the secret committee:

#### ORIGINAL WORK

Gold Medal — Booth No. 8

Title: Plasma Without Jaundice; An Indispensable Therapeutic Agent.

J. Garrott Allen, Daniel N. Everson, Carolyn Sykes, Morris Levine, and Louis Head.  
University of Chicago.

#### EDUCATIONAL VALUE

Gold Medal — Booth No. 10

Title: The Graphic Methods in the Study of the Cardiac Patient.

Aldo A. Luisada.  
The Chicago Medical School.

Silver Medal — Booth No. 17

Title: Cutaneous Manifestations of the Leukemia-Lymphoma Group.

Samuel M. Bluefarb and Stephen O. Swartz.  
Cook County Hospital (Hektoen Institute)  
Northwestern University Medical School.

Bronze Medal —

1. Booth No. 13

Title: The Neuropathic Arthropathy of Feet  
Donald S. Miller, William F. Lichtman  
The Chicago Medical School.

2. Booth No. 14

Title: Structure and Functions of the External Nasal Pyramid  
Maurice H. Cottle, George G. Fisher, Roland M. Loring

The Chicago Medical School, Cook County Hospital  
Illinois Masonic Hospital

3. Booth No. 23.

Title: Dissection on Continuity for Cancer of the  
Head and Neck

Hans VonLeden, Jesse E. Waller, Chicago.

The president thanked Dr. Mason and his Committee for their fine work in lining up exhibits for this Annual Meeting. Dr. Lewis urges all delegates to visit the Scientific and Technical Exhibits during this session. The president called for the reading of the minutes of the Second Session of the House of Delegates. Motion: Leo P. A. Sweeney, that the reading of the minutes be dispensed with, second by E. V. McCarthy and carried.

President Lewis stated that the election of officers was next on the order of business. He entertained nominations for the office of President-Elect. Darrell H. Trumpe, Springfield, nominated F. Garm Norbury of Jacksonville for the office of President-Elect. The nomination received a second by Charles Eck. As there were no other nominations, Motion: Hoeltgen, second Percy E. Hopkins, that nominations be closed, the Secretary cast the affirmative ballot for Dr. Norbury as President-Elect. Motion carried, and the ballot cast for Dr. Norbury. Dr. Norbury was escorted to the rostrum and thanked his many friends for the trust they had placed in him and gave his assurance that he will carry on to the best of his ability, and asking for assistance and cooperation.

Dr. M. M. Hoeltgen nominated Louis R. Limarzi for the office of First Vice President. There being no other nominations, motion, Percy E. Hopkins, that the nominations be closed and the Secretary be instructed to cast the affirmative ballot for Dr. Limarzi for the office of First Vice President. Second by Harry Mantz, Alton and carried. Secretary cast the ballot for Dr. Limarzi. Dr. John E. Bohan, Alexis, nominated J. C. Redington, Galesburg for the office of Second Vice President. There being no further nominations, E. E. Davis moved that the nominations be closed and the Secretary instructed to cast the affirmative ballot for Dr. Redington; second by John R. Wolff, and carried; Secretary casting the affirmative ballot for Dr. Redington.

W. W. Fullerton, Sparta, nominated Harold M. Camp to succeed himself as Secretary-Treasurer. There being no further nominations, Fred Muller, Chicago, moved that the nominations be closed, and the President cast the affirmative ballot for Dr. Camp to succeed himself as Secretary-Treasurer; second by several and motion carried, the President casting the affirmative ballot.

Election of Councilors. In the Third District the terms of George A. Hellmuth and Raleigh C. Oldfield expiring. Maurice M. Hoeltgen nominated Earl H. Blair to succeed Dr. Hellmuth, who is leaving the state. Second by Fred Muller. There being no additional nominations, motion G. Henry Mundt, that the nomina-

tions be closed and the Secretary instructed to cast the affirmative ballot for Dr. Blair, motion carried, and ballot cast for Dr. Earl H. Blair. Dr. Hoeltgen nominated Raleigh C. Oldfield to succeed himself for the three year term. H. Kenneth Scatliff moved that the nominations be closed and the Secretary instructed to cast the affirmative ballot for Dr. Oldfield; second by Robert Mustell, and motion carried; the ballot cast for Dr. Oldfield to succeed himself.

As the term of Warner H. Newcomb, Councilor for the Sixth District was ended, Harry Mantz, Alton, nominated Dr. Newcomb to succeed himself for the three year term, second by Arthur Goodyear, who moved that the nominations be closed, and the Secretary instructed to cast the affirmative ballot for Dr. Newcomb; second by E. E. Davis, and motion carried; the ballot was cast for Dr. Newcomb. J. A. Petrazio, Ava, nominated Burtis E. Montgomery to succeed himself for a three year term as Councilor for the 9th District; motion, Leo P. A. Sweeney that the nominations be closed and the Secretary cast the affirmative ballot for Dr. Montgomery to succeed himself; second by Elmer McCarthy, and motion carried. The ballot was cast for Dr. Montgomery.

Dr. Gerard Dundon, Columbia, nominated W. W. Fullerton to succeed himself as Councilor for the 10th District; W. H. Walton, Belleville, moved that the nominations be closed and the Secretary instructed to cast the affirmative ballot for Dr. W. W. Fullerton; second Gerard Dundon, and motion carried; the ballot was cast for Dr. Fullerton to succeed himself for another three year term.

Election of Delegates to the American Medical Association. Delegates are elected for a two year term, beginning January 1, 1955. Terms expiring at this time, Percy E. Hopkins, Warren W. Furey, Charles H. Phifer of Chicago, Bernard Klein, Joliet and B. E. Montgomery, Harrisburg. Dr. M. M. Hoeltgen nominated Drs. Hopkins, Furey and Phifer to succeed themselves for the two year term. Fred Muller moved that the nominations be closed, and the Secretary instructed to cast the affirmative ballot for the three men to succeed themselves; second by R. H. Hayes, and motion carried. The ballot was cast for Drs. Hopkins, Furey and Phifer.

Dr. Arthur Goodyear nominated C. Paul White, Kewanee, to succeed Dr. Klein; Dr. Joseph T. O'Neill nominated B. E. Montgomery to succeed himself. By proper action both were elected for the two year term.

Alternate delegates to the American Medical Association. Terms expiring, James H. Hutton, Karl L. Vehe, and G. Henry Mundt of Chicago, James E. Wheeler, Belleville, and Joseph T. O'Neill, Ottawa. Dr. Hoeltgen nominated Drs. Hutton, Vehe and Mundt to succeed themselves. Dr. Paul Dailey, Carrollton, nominated Harry Mantz, Alton, to succeed Dr. Wheeler, Burtis E. Montgomery nominated Joseph T. O'Neill, Ottawa, to succeed himself. By proper action, the five candidates were elected as alternate delegates to the A. M. A. for a two year term.

Election of Standing Committees. Medico-Legal

Committee, two members to be elected for a term of three years. By proper action, Drs. George C. Turner, Chicago, and A. L. Nickerson, Kankakee, were re-elected to succeed themselves for the three year term.

Committee on Medical Education and Hospitals. Drs. George F. O'Brien and Karl Vehe, Chicago, and Harlan English, Danville, were re-elected as members of this committee.

Committee on Medical Benevolence. Robert H. Hayes, Chicago, was re-elected for a three year term on this committee.

Committee on Medical Testimony. Drs. Walter L. Palmer, Chicago, and Arthur F. Goodyear, Decatur, were re-elected for a four year term on this committee.

The Grievance Committee. Drs. Percy E. Hopkins, Chicago, and E. H. Weld, Rockford, were re-elected for a three year term on this Committee.

Following the election, President Lewis called upon C. Paul White to present a supplementary report from his Reference Committee. The resolution on Amendments to Standards for Hospital Accreditation, as presented at the first Session of the House, was reported on by Dr. White. White stated the committee recognized the inroads being made by lay groups, especially lay hospital boards, on the control of medical practice. We find ourselves in complete accord with the thinking of the South Chicago Branch of the Chicago Medical Society and the C. M. S. Council, and recommend the adoption of this resolution; and I so move; second by Harry Mantz, Alton. The proposal was discussed by Harry Mantz, in some detail. There being no further discussion, the motion was put and carried.

The President called for report of Reference Committee "A", John R. Wolff, Chairman. The Committee reviewed the annual reports of three Council Committees; The Editorial Board and the Journal Committees, the Advisory Committee to the I. P. A. C. and the Advisory Committee to the Veterans' Administration. The Committee also reviewed the reports of the Editors of the Illinois Medical Journal, the Illinois Delegates to the A. M. A. and one resolution which was referred to them by the President. Dr. Wolff commented on the report of the Editors, approving changes made in the Illinois Medical Journal during the past year. The Committee emphasized the need of more articles written by general practitioners. The new type of binding was commented upon, and definitely approved as a forward step in its publication. Abstracts from the House of Delegates, from Council meetings and important committee meetings should be published occasionally for the interest of members of the Society. The committee commends the business manager, Mr. L. E. Malley for his fine work in this capacity. The work of the editors is likewise commended.

Dr. Wolff moved the adoption of this portion of the report, second by E. E. Davis and carried.

The report of the Editorial Board and Journal Committee, was reviewed and the interest and work of these two groups was approved. The joint meetings were also approved heartily. By proper action this portion of the report was approved. The Medical Advisory

Committee to the Illinois Public Aid Commission was then reviewed. The Committee is not only representing the doctor, but is also interested in helping provide good medical care for the recipients of clients of the I. P. A. C. on a low cost basis. Always realizing that this is a program for medical care to a large group of public assistance recipients and with limited appropriations by the State Legislature, the Committee is constantly keeping these facts in mind. The Committee hopes this friendly relationship between a Society Committee and a State government Agency will be maintained. By proper action this portion of the report was approved.

The home town care of veterans with service-connected disabilities was discussed, as shown in the report of the Medical Advisory Committee with Percy E. Hopkins as its chairman. The Committee noted the excellent spirit of cooperation shown in this work, and that the program was going on smoothly. This portion of the report was approved.

The report of the delegates to the A. M. A. from Illinois was reviewed, and the committee desired to congratulate the State Society for the fine choice of delegates selected to represent them. The report well summarizes the principal actions taken by the A. M. A. House during the past year. The Reference Committee is proud of the showing of the Illinois State Medical Society in leading the nation in its contributions to the American Medical Education Foundation. The Committee hopes that this Society will continue to permit its members to make the \$20.00 per annum donation to this worthy fund. By proper action this portion of the report was approved.

The Reference Committee reviewed the resolution referred to it, as coming from the Adams County Medical Society. In this resolution the Adams County Society was requesting the Illinois delegates to the A. M. A. to introduce resolutions in the A. M. A. House in the effort to get the A. M. A. to abandon scientific sessions and exhibits at the annual interim meeting, if not to abandon the meeting entirely. The committee appreciates the fact that there are many medical meetings, as there are many medical societies, yet we cannot help but recognize the great work being done by our A. M. A. in both its annual and clinical or interim sessions. The annual meeting must be in a large city having adequate facilities for meetings, exhibits, and places to house the many who attend them. There are only three or four such cities in the nation where the annual meetings may be held. The interim, or clinical meetings, are arranged in various parts of the nation to give many members the opportunity to see the A. M. A. in action who may not have the opportunity to attend the annual meetings. It thus brings the scientific sessions and scientific exhibits to the home of many of these members who are unable to travel a great distance to attend meetings. With this in mind, the Committee feels that the interim sessions should be continued, and does not approve this resolution. Wolff moved that the resolution be not approved, second by Charles Eck and motion carried. Dr. Wolff then moved the adoption of the report as a whole, second by Dr. Pfeifferberger, and carried.

President Lewis called for the report of reference Committee "B" with Dr. J. C. Redington as chairman. The Advisory Committee to the Woman's Auxiliary report and that of the President of the Woman's Auxiliary were discussed. The actions of the Advisory Committee were approved, and the committee is well aware of the many activities which have been referred to this committee and commend the committee for their actions. All members of this Society should read the report of Mrs. Christiansen, President of the Auxiliary, and see how any important activities are given consideration by this fine group. They are commended by the reference committee, with the hope they will continue in their fine work. This portion of the report was approved by the House of Delegates.

The Committee reviewed the report of the Medical Advisory Committee to the United Mine Workers health and Welfare Fund, and they heard the chairman, Dr. W. E. Monaghan, and the regional director, Dr. Cecil A. Z. Sharp discuss many of the details connected with their work. The committee is satisfied that this advisory committee is doing fine work and should be commended for the way they are doing it. This portion of the report was then approved.

The Advisory Committee to the American Legion — Illinois Department is a relatively new committee appointed by the President of this Society, at the request of Illinois Legion officers. The report is interesting and gives in summary both sides of the questions pertaining to the care of disabled veterans. The reference committee urges membership as a whole to not only read the report, but also keep informed on this subject, which has attracted so much attention on the national level. This portion of the report was approved.

The Committee heard discussions from Carl Steinhoff, Chairman of the Medical Advisory Committee to the Selective Service System, and the committee is obviously carrying on its work in a very satisfactory manner. This portion of the report was approved.

Reports of the Committee on Blood Banks, and Committee on Cancer Control were reviewed by the reference committee, and both were of much interest to the group. Redington moved the adoption of these portions of his report, second by Walter E. Kittler, and carried. He then moved the adoption of the report as a whole, second by J. O. Cletcher, Tuscola, and carried.

President Lewis then called for the report of the Reference Committee "C", Percy E. Hopkins, chairman. Hopkins first reported upon the rewritten report of the Committee on Cardiovascular Diseases, and it was the opinion of the committee that this committee is doing a laudatory job, much needed in the state. It was noted that apparently good cooperation had been established and is being maintained by several agencies interested in this problem. Among these agencies, the Crippled Children's Service, and the Illinois Heart Association. The Reference Committee approves this report and commends the Cardiovascular Committee for its efforts. This portion of the report was approved.

The report of the Committee on Crippled Children's

Clinics was most interesting, and it was noted that clinics are being held in a majority of the counties of the state providing a reasonable accessibility of institutions for practically all crippled children in the state where clinics are held quite regularly. The fact that no complaints from local medical societies have been made during the year, speaks well for the University of Illinois participating in this program. The Illinois State Medical Society may well be proud of the fact that the crippled children in this state are well cared for. This portion of the report was approved.

The Committee to Investigate the Coroner's Office was reviewed. The committee believes the title of this committee is improper, and they believe a more fitting title could be "Committee for the Proposed Revision of the Coroner's Office". The reasons for this proposal need no further comments here. The reference committee is entirely in sympathy with the efforts now being put forth in conjunction with the Illinois and Chicago Bar Associations which it is hoped will culminate in effecting the desired changes in this office. It might be well for the House of Delegates to reiterate its approval of the efforts of this committee. This portion of the report was adopted.

The report of the Committee on Diabetes was reviewed by Dr. Hopkins, noting with regret the death of a member, Willard O. Thompson. The Committee notes with satisfaction that the State Health Department facilities have been utilized in the effort to make the population and the medical profession of the state, diabetes conscious. They commend the continued cooperation on the part of the State Health Department in this project. This portion of the report was approved.

The Educational Committee report was reviewed by the Committee, and the Educational Committee with its many and various activities was commended for a further dissemination of health information. The committee is aware of the fact that television is of tremendous importance as a medium for health education and they also believe that the utilization of other media are still of great value for this purpose. The use of radio, the conducting of an active speaker's bureau, plus the publication of HEALTH TALK are all means by which health information may be provided. Reference was made to the new educational television to be developed in Chicago, and the possibility that this Society might donate to the fund necessary to get it established. It is the opinion of the Committee that the Council should give this matter serious consideration. This portion of the report was approved.

The Report of the Ethical Relations Committee was reviewed by this Reference Committee, Dr. Hopkins noting that the report was quite brief. Two cases were cited in this report. In the Springfield case the appeal was taken to the A. M. A. Judicial Council, which later upheld the action taken by the local county society, then by the council of the state society. The committee commends the personnel of this Ethical Relations Committee for its efficiency and demonstrated ability. This portion of the report was approved.

Report of the Constitution and By-laws Committee was reviewed, and the resolution introduced by Dr. Furey was carefully examined. In this resolution, interns and residents were to be induced to become members of organized medicine, and the committee desires to make some changes in the resolution-to-wit:

THEREFORE BE IT RESOLVED THAT this House of Delegates go on record as endorsing a type of membership for physicians (1) who are serving internships, and (2) physicians who have been licensed to practice medicine in any one state, and/or are serving residencies and fellowships, within the first five years following graduation, with due allowance for time spent in military service. The Committee proposes the following changes in the proposed amendments to the Constitution;

Amend Article IV, Section 1, line 2 by adding the following words after residency members, "Intern Members",

Amend Article IV, present Section 4, titled "Residency Members by the following:

1. Delete the words "in the State of Illinois" on lines 2, 3, 4, and 5.

2. Change \$5.00 per capita, line 1, paragraph 2, to \$2.00 per capita.

3. Add the following: "When his training ceases, the physician's residency membership will cease at the end of that year, and, if he wishes to become a member of the Society, he must apply for regular membership through his component Society.

4. Add a new section 4 titled: Intern Members.

Any person who is a graduate of an approved medical school of The United States or Canada, who is a citizen of the United States and who is of good moral and professional standing and who is serving an internship in any hospital in the State of Illinois approved by the Council on Medical Education and Hospitals of the American Medical Association is eligible for intern membership for a period of not more than two years after graduation on the recommendation of any two members of this Society who are also members of his Hospital Staff. When his training ceases the physician's intern membership shall cease at the end of that year, and, if he wishes to become a member of this Society, he must apply for Residency or regular membership through his component society. Dues for Intern Membership shall be . . . . minimal.

5. Amend Article IV by changing Sections 4, 5, 6, 7, and 8, to Sections 5, 6, 7, 8 and 9.

Then the *Article IV — Composition of the Society* will read as follows:

"Section 1. This Society shall consist of members, emeritus members, residency members, interns, government service members, past service members, retired members, honorary members, and guests."

"Section 2 — Same as printed on pages 3 and 4.

"Section 3 — Same as printed in page 4.

"Section 4 — Same as printed above.

"Section 5 — *Residency Members*. After being licensed to practice medicine, a physician serving full time as a resident or fellow in an approved hospital

may enjoy all the privileges of full membership at a special rate up to five years after graduation in medicine, except that time spent in military service may be excluded in calculating the five year limit. Thereafter the full rate shall apply. The special rate shall be \$2.00 per capita per annum. A residency member must be a graduate of an approved Medical School in the United States or Canada, have a degree or Doctor of Medicine or its equivalent, must be a member in good standing of his component Society and must be a citizen of the United States."

When his training ceases, the physician's residency membership shall cease at the end of that year, and, if he wishes to become a member of this Society he must apply for regular membership through his component Society.

"Section 6 — (formerly Section 5) remains the same as printed on page 5.

"Section 7 — (formerly Section 6) remains the same as printed on page 5.

"Section 8 — (formerly Section 7) remains the same as printed on page 5.

"Section 9 — (formerly Section 8) remains the same as printed on page 5."

Dr. Hopkins moves the adoption of this portion of the report. Second by Charles H. Phifer, and carried.

Dr. Hopkins: if it be in order I would move that these proposed amendments to the Constitution and By-laws be approved on the basis of their being in order, having been read at a previous session of this House. This would save holding over for a year. If it is not out of order, Mr. President, I would move that they be adopted at this session in toto. Second by Dr. Pfeifferberger. The President: I so rule. Motion called for and passed. Dr. Hopkins then thanked the members of his committee who worked diligently on the report, then he moved, second by Leo P. A. Sweeney, that the report as a whole be adopted. Motion carried. The President thanked Dr. Hopkins for a fine report. The next report called for by the President was that of Committee "D" and in the absence of its chairman, Dr. George Callahan, Dr. John E. Bohan was asked to present the report. Dr. Bohan referred to the report of the Fifty Year Club Committee, commends its chairman, Dr. Andy Hall, and moves the adoption of the report, second by Caesar Portes, and approved.

Committee on Industrial Health. In addition to the printed report, this Committee submitted a supplementary report, referring to a conference held with the Industrial Health Commission at which preliminary discussions occurred covering administrative and professional relations. It is anticipated that an additional conference will be held with this group in the near future. Additional conferences are being arranged with the following interested groups: The C. I. O. Illinois Industrial Union Council, Progressive Mineworkers of Illinois, Committee on the Industrial Commission of the Chicago Bar Association, Executive Committee Section on Workmen's Compensation Law of the Illinois Bar Association, Illinois Manufacturer's Association, and the Illi-

nois Federation of Labor. Following the conferences it is expected that specific recommendations can be presented to the Council of the Illinois State Medical Society relative to a legislative program. The Reference Committee therefore recommends approval of the Committee's report as published in the handbook and the supplementary report. This committee also recommends that the House of Delegates authorize the Council to approve such legislative endeavor as it shall determine from the recommendations of the Committee on Industrial Health. The survey of Medical Relations of Workmen's Compensation in Illinois by the Council on Industrial Health of the A. M. A. and the Committee on Industrial Health of the Illinois State Medical Society, has been reviewed by all members of the reference committee. The Committee recommends that this be read by all members of this House of Delegates. This portion of the Committee report was approved.

The Interprofessional Relations Committee report was reviewed by the Committee, and this work is hereby commended. The committee recommends that efforts be made throughout the State to get members of the Illinois Bar Association active in this Council, as recommended by members of the Interprofessional Relations Council who appeared at the hearings. This portion of the report was approved.

The report of the Maternal Welfare Committee was reviewed, and heartily approved. The Committee calls to the attention of members that the chapter on Obstetrics and Gynecology for the History of Medical Practice in Illinois, from 1850 to 1900, has been written by the chairman of the Maternal Welfare Committee, Dr. Frederick H. Falls.

The Committee likewise reviewed the interesting report of the Committee on Medical Economics, and recommends its adoption. These reports were approved by the House.

The resolution to approve sponsorship in Illinois of the 1955 A.A.P.S. Essay Contest was referred to this Committee. By proper action this resolution was approved.

The Committee on Medical History Report was gone over carefully, and the Reference Committee recommends its approval as published in the handbook. They believe it important to have the book published in the very near future. Dr. Bohan moves that this portion of the report be adopted, second by E. V. McCarthy. This matter was discussed by E. S. Hamilton as Chairman of the Finance Committee of the Council. He is anxious to see proof that a sufficient number of copies will be sold to justify the expense of its publication. Dr. Hamilton requested the floor for Dr. Hutton, as chairman of the Committee on Medical History. Dr. Hutton gave an interesting report of the work which has been done in procuring the vast amount of material necessary to produce the book. He told many interesting stories of physicians and their practice in Illinois, as brought out in this extensive historical research. But-ton told of repeated efforts over a long period of time to get a history of medicine in Illinois, and with the

exception of the volume edited in 1927 by Dr. Lucius H. Zeuch, all other plans had failed. He urged that this House go on record as approving the publication of the book, and so recommending to the Council of its desires to have same published. Several other members of the House participated in this discussion, among these E. H. Weld, David B. Freeman, G. Henry Mundt and others. Following this discussion that portion of the reference committee report was approved. Dr. Bohan then moved that the report as a whole be approved, second by Robert H. Hayes, and carried. President Lewis thanked Dr. Bohan for his fine report.

Dr. Warren W. Furey was then called to give the report of Reference Committee "E" which had the following to review:

1. Military Affairs and Emergency Medical Service
2. Committee on Necrology
3. Committee on Nursing
4. Committee on Nutrition
5. Committee on Physical Medicine and Rehabilitation
6. Committee on Mental Health

A supplementary report of the Committee on Nutrition, and three resolutions, one on nursing and two on mental health also were reviewed. Dr. Furey stated that these reports were all published in the handbook and they represent a story of a tremendous amount of work well done by active members of this Society. The reference committee commends all of those who had to do with these very important undertakings and congratulates them for a job well done. This portion of the report was approved.

In addition to the information contained in the report of the Committee on Military Affairs and Emergency Medical Service, the chairman of the Committee appeared before the reference committee to tell of the inadequate preparations to cope with certain types of emergencies, such as the explosion of an atomic bomb. The inadequacy is apparently due to lack of appropriations by municipalities and the state for such emergencies which could arise. It was recommended that this again be called to the attention of the Governor and other concerned agencies requesting favorable budgetary provisions to fulfill this important and worthwhile need. This portion of the report was approved.

Dr. Furey referred to the Report of the Committee on Necrology, expressing sorrow for the passing of so many members during the past year. He recommended that the Delegates rise for a moment of silent prayer out of respect to the memory of these, our departed members. Dr. Hayes, as chairman of the Committee on Necrology, was called upon for comments. Dr. Hayes called attention to the names of additional members who have died during the past year and whose names did not appear in the handbook. He desired that they appear on the Society records, as follows:

- Robert Cummings, died in Florida late in 1953
- John Ziegler, Farmer City, died in 1953
- Louis Beehler, Chicago, died during 1953

Roy Williams, Antioch, died in 1953

Samuel Clark, Jacksonville, died May, 1954

Dr. Furey's motion was seconded by W. E. Kittler, and all present, stood for one minute in respect to the memory of these departed members.

Dr. Furey then reported on the Report of the Committee on Nursing, which he stated contained much important information on the present nursing situation in Illinois. He called attention to the seriousness of the ever increasing shortage of nursing personnel not only in our area, but throughout the country as well. Current problems are well presented in this report and deserve the careful study of all members of the profession. The Committee on Nursing strongly urges that everything possible be done to keep our present schools of nursing, and that we exhaust every means to obtain more hospital schools of nursing and increase the enrollment in these schools. A resolution to further this recommendation presented by Joseph T. O'Neill of the Society Council was discussed at length by Dr. O'Neill, Dr. Maurice Hoeltgen, Chairman of the Committee on Nursing, and by Dr. Homer D. Junkin of Paris, Illinois. The reference committee is in agreement with the recommendation in the resolution. This portion of the report was adopted.

A supplementary report was presented by the Committee on Nutrition, in which reports of meetings attended by the chairman and members of the committee were given. An outstanding feature of one of these meetings was the tour of inspection of the new laboratory equipment which consisted of a large mass spectrograph, an infrared spectrophotometer, and various other scientific instruments for determining the amount of minerals, enzymes, hormones, etc.. This laboratory is the first of its kind in the United States. They will examine blood and tissue, food and the soil from which the food is taken to determine the relationship of soil and food to health. It was the hope of the writer of the report that such a laboratory will be set up in Illinois in a medical school, and in the Department of Agriculture in our universities. Dr. Furey stated that his reference committee concurs in the suggestion and agrees with both reports. This portion of the report was adopted.

The report of the Committee on Physical Medicine and Rehabilitation was quite brief, and they recommended the appointment of a qualified physician to the State Board of Examiners for Physical Therapists. The reference committee concurs in this recommendation, and this portion of the report was approved.

Dr. Furey discussed the report of the Committee on Mental Health, in which attention is called to physicians in general practice as well as to specialists to the phases of the mental health problem, and they recommend:

1. Distribution of a copy of the Psychiatric Bulletin to each member of the Society

2. The appointment by each component and branch society of a Committee on Mental Health

The reference committee concurs in these recommendations, and this portion of the report was approved.

Furey referred to two resolutions introduced by Dr.

Baer, delegate from Peoria and they were considered at considerable length, with a group of Society members interested in medical care and administrative management of state mental institutions, present. The first of these had to do with the appointment of chief administrative officers. It was the opinion of the committee that the original resolution was too pointed in that it cited a single incident as a cause for the proposed action. It was agreed by Dr. Baer and others present that a short substitute resolution recommending basic principles was all that was necessary. The following substitute motion is hereto presented:

*Whereas*, it has come to our attention that a basic principle of the American Psychiatric Association recommending that a psychiatrist as an administrator is essential to the optimum care of patients in institutions for the mentally ill,

*Therefore be it resolved*, that the Illinois State Medical Society voice its approval of this basic principle and recommend to the Governor of the State of Illinois and the concerned governmental agencies that they do everything possible to follow it. Furey moved the adoption of this portion of the report. Dr. Norbury was asked to discuss the substitute resolution; he stated that he was present at the hearing of the reference committee when the resolution was being considered. He knew about the resolution, and expressed himself previously as going along in principle with the American Psychiatric Association about mental hospital administrators. He believed it is better for the Society to go along with the general principle rather than to point to any individual situation at the present time. Furey's motion, second by W. H. Walton, was put and carried.

Dr. Furey stated that the second resolution was much more controversial than the first one, and much time was spent by the Committee in discussing it and the events that transpired following its introduction at the first session on Tuesday morning. The Reference Committee believes that this matter was one which should have been considered and acted upon by the Society before presentation to the public. The premature publication of the report seemingly made it appear that the Society had some part in the action. This portion of the report was approved.

In further considering the resolution it was learned that the report referred to from the American Psychiatric Association had not as yet been received by the State Agencies requesting it, but that a statement concerning it was probably on the Governor's desk on May 19. It was the opinion of the psychiatrists present that a reaffirmation of the action taken by the House of Delegates in May, 1953, would answer the intent of the present resolution and the suggestion was made that the committee activated as a result of that action should diligently pursue the assignment of the House. The following recommendation by the reference committee at the 1953 meetings of the House of Delegates was approved:

"The Reference Committee recommends that the Illinois State Medical Society appoint a committee of

three or five members to study the status of the mental institutions and to make recommendations to the House of Delegates for definite steps for improvement by the State authorities". Dr. Furey moves the adoption of this section of the report and request that this committee be continued. Second by J. J. Moore, and carried. Dr. Furey stated: Having taken this action, I move that the resolution as presented, be *not* adopted. Second by Joseph T. O'Neill, and carried.

Dr. Furey and his committee expressed their appreciation to those who appeared before the committee and added much information which helped materially in their deliberations. Dr. Furey then moved the adoption of the report as a whole, second by E. V. McCarthy and carried.

The President recognized Dr. Otto Bettag, Director, State Department of Public Welfare, who thanked the delegates for their keen interest and fair play in their actions.

The Committee on Miscellaneous Business, with Paul A. Dailey, Carrollton, as Chairman was called upon for their report.

The Committee considered the report of the Committee on Post Graduate Education, commending Dr. Hellmuth and his secretary, Mr. James C. Leary for their work in behalf of the Committee. This portion of the report was approved.

Committee on Rural Medical Service; The farmer-doctor Loan Fund program was commended for the efforts in getting more physicians in the rural areas. One interesting feature which should be emphasized is the fact that this venture is completely financed by private enterprise. This section of the report was approved.

The Committee on Scientific Service: This committee is commended for a fine job done well. The Committee requests that speakers be arranged for, as far in advance of the date of the meeting as possible. Miss Fox and her associates in the Chicago office have ably supported the work of this Committee. This portion of the report was approved.

Committee on Tuberculosis Control: Dr. Dailey calls to the attention of the Delegates, the list of recommendations made in the report, on page 179 of the handbook.

Particular attention was called to recommendation number three, which would make compulsory hospitalization of uncooperative open cases of tuberculosis. This portion of the report was approved.

Committee on Voluntary Pre-Payment Plans: The Committee notes with pleasure the rapid growth of the voluntary prepayment medical care plans, as indicated in the printed report, and also in the supplementary report presented by the Committee Chairman, Dr. Percy E. Hopkins. This portion of the report was approved.

The Committee had some resolutions referred for consideration by the President. The resolution introduced by Dr. Pliny Blodgett, opposing the expansion of Social Security and the inclusion of physicians in the social security system. The Committee approves this resolution, and Dr. Dailey moves that it be approved. Second by E. V. McCarthy and carried.

Resolution No. 3, supporting action to determine the

position of all candidates on the Bricker Amendment and the proposed 23rd Amendment. This resolution urges that every member of the Society undertake to ascertain the stand taken by all candidates for public office on two issues. The Committee feels that it should not be necessary to exhort our membership to exercise their rights and obligations of citizenship, and, therefore, recommend that this resolution be not adopted. Dr. Dailey moves the adoption of this portion of the report, second by E. V. McCarthy.

Dr. Blodgett discusses the motion, telling why he believes affirmative action should be taken, and he offered as a substitute motion that this House endorse the resolution, second by E. V. McCarthy. The President called for a vote on the substitute motion—are you in favor of the substitute motion? The ayes have it. There was considerable discussion of the procedure, and to exactly what had transpired. Dr. Furey was called upon to explain the procedure; stating that the substitute motion had not as yet passed, and is now before you for consideration. A standing vote was called for, and the substitute motion was approved. Dr. Dailey then considered the resolution on HR-6949 and H.R.-8356 — S-3114. (Resolution No. 1, first session of the House.)

The Committee agrees with the objectives of this resolution, but recommends that only the first three of ten whereases be included. The resolution recommended by the Committee is as follows:

*Whereas*, Congressman Charles A. Wolverton on January 6, 1954, introduced HR-6849 which would establish a federal corporation to reinsure the voluntary non-profit health plans, and

*Whereas*, Congressman Charles A. Wolverton and Senator Alexander Smith introduced on March 11, 1954, HR-8356 and S-3114 (identical bills) which would establish a federal corporation to reinsure virtually every type of health plan providing it is based on prepayment, and

*Whereas*, federal reinsurance would be a form of federal subsidization of the health plans,

*Therefore be it resolved*, that the members of the Illinois State Medical Society in regular session assembled this 21st day of May, 1954, oppose the passage of H.R. 6949 and HR-8356—S-3114 and all similar legislation which propose federal reinsurance or direct federal subsidization of the voluntary and private health plans.

Dr. Dailey moves the adoption of this portion of the report, second by C. Paul White and carried.

Liaison Committee on Medical Education: The Reference Committee had extensive hearings on the Liaison Committee's report and its Supplementary Report, as presented before the first Session of this House of Delegates. E. V. McCarthy moved that the House go into Executive Session, second by G. Henry Mundt, and carried.

After arising from executive session, Dr. McCarthy moved that the House concur in the action taken in

executive session—second by Leo P. A. Sweeney, and carried.

Dr. Edwin S. Hamilton thought the press was entitled to know what action had been taken in executive session, as definite action was taken on the resolution. Dr. Mundt moved that information of the action taken be given to the press, Second by James H. Hutton. The motion was put, and was unanimously carried.

The next order of business was the fixing of the per capita assessment for 1955. Harlan English moved that the dues remain the same as for 1954; second by W. E. Kittler, and carried.

There being no further reports, the President asked the chairman of the Committee on Credentials, Dr. English, to give a report for the records. Dr. English stated that 144 delegates and officers had been certified, which constituted the voting strength for the Session. English moves the acceptance of this report, second by E. S. Hamilton and carried.

The Secretary stated that in his annual report he asked the House to express its opinion on the arrangement for the three sessions of the House. This will be of much assistance in making the arrangements for the next Annual Meeting, and the sessions of the House of Delegates.

G. Henry Mundt moved that we have the same general arrangement for the 1955 annual meeting as we had this year; second by Chas. P. Blair, and carried. The Secretary also urged that next year delegates desiring to introduce resolutions submit them to the Secretary's office in time for inclusion in the handbook. The House went on record a year ago that this be done, yet we received only three resolutions before the date of going to press for the handbook. He would suggest that next year resolutions be sent to the Secretary's office at least one month before the date of the meeting, as it will be of much benefit to the delegates to read these resolutions and perhaps get expressions in advance of the meeting from their own component societies.

The Secretary also asked for official permission to thank those who have worked so diligently in the effort to make this 1954 annual meeting an outstanding one. Motion, E. S. Hamilton, second Russell M. Jensen, that this be given; motion carried.

Dr. James H. Hutton moved that the House of Delegates ask the Woman's Auxiliary to adopt the sale of the Medical History of Illinois as one of their major projects for the next year; second by E. E. Davis, and carried.

President Lewis thanked the entire membership, the Council, Committee personnel and officers who have carried on the functions of this Society. He appreciates the fine cooperation he has received, and for the many new friends he has made, he is thankful to all of them. Commenting on a great General who said some three years ago, "There is no substitute for victory", Dr. Lewis says there is no substitute for good friends and friendship.

INDUCTION OF THE PRESIDENT-ELECT:

Dr. Lewis asked Warren W. Furey and Leo P. A. Sweeney to escort President-Elect Arkell M. Vaughn and Mrs. Vaughn and their son, Joseph, to the rostrum. Lewis commented on the fact that this is Mrs. Vaughn's birthday and their son, who is a medical student in Ireland, flew into New York the previous day so he could be present on this occasion.

Dr. Lewis said: "Dr. Vaughn, before I induct you into the office of President of this fine organization, I wish to express my appreciation for your fine help during the past year. You took care of many chores for me in the Northern part of the State and outside the State when it was impossible for me to be there. I wish to thank you for this fine service.

It is now my pleasant duty to pin this badge of authority on you. I am sure you will enjoy this office. The Illinois State Medical Society is one of the greatest medical societies in the entire Nation. I present you with this official gavel, and salute you as the President of the Illinois State Medical Society.

ACCEPTANCE ADDRESS

Dr. Lewis, members of the House of Delegates of the Illinois State Medical Society, and friends:

I accept this signal honor of the presidency of the Illinois State Medical Society, though with mingled feelings of both humility and pride. And I pledge my full support, and energies to the high purpose of this society in the office which you have so graciously given me.

I fully recognize that the president of this great organization is only a link in a long chain. He is only one among the other officers, the chairman of the Council, the House of Delegates, the Council, the committees and the 92 county medical societies with their membership, who comprise the grass roots of the society. Each one of them is a part of this great organization and each has a voice in its management, which is as it should be, in any democratic organization. I shall do my best in the role in which you have cast me, seeking to carry my share of the work as efficiently as they do.

Today we are facing many important problems, which I am sure can be amicably and prudently solved by honest discussion. Our forefathers, our predecessors in the 114 years since the formation of this society in 1840 were likewise confronted with important problems peculiar to their time. They solved their difficulties in prayer and discussion and their decisions paved the way for us and made possible the growth and expansion of this great society. I sincerely hope we can do as well.

The greatest danger among the problems which confront us today is the horrible specter of Socialism and Communism, with spreading tentacles stretching out in all directions in their attempt to engulf us. I speak of our own and other free countries as a whole, not only of the medical profession, which is a small but important segment in the whole scheme.

For that reason we in our profession must be eter-

nally vigilant. Our medical students, our interns, and our residents should be fully indoctrinated to the evils of Socialism and Communism.

I would go so far as to require every graduate of a medical school in the United States to sign an Oath of Loyalty to the Constitution before admission to his local society and to the Illinois State Medical Society. You can rest assured that if any candidate has no wrong doing or evil in his heart, he *will not hide* behind the skirts of the 5th amendment.

One has only to attend the meetings of the Council and the committees and of this House of Delegates session to realize that the society is in safe hands. When I look around this room today, I see in your faces the sincerity of the purpose for which you are assembled. You have discussed, sincerely, thoughtfully, and prudently, many of our problems and reached many serious decisions. With such men as *you*, any organization is safe to hand down to our successors, the younger physicians of Illinois.

What does the future hold? Of course no one knows. But with faith and hope in our *youth*, as our predecessors had in us, I am *sure* the society under

*their* leadership will prosper and prevail.

Recently the 80-year old Otto Harbach, famous popular composer, was asked on a television program what *he* thought the future held. His reply was a penetrating observation, which I want to repeat to you. He said very simply: "Read, if you can, the strange and baffling eyes of youth." That is where we will find our answer as well.

In closing, I again pledge my untiring strength and support in an effort to make the coming year as successful as the preceding one for *our* Illinois State Medical Society. This is indeed a high ambition for any man. I leave you with this thought:

"In the path of life do your very *best* and *God* will do the *rest*."

I thank you.

PRESIDENT VAUGHN: If there is no further business I will entertain a motion for adjournment.

Dr. W. E. Kittler, Rochelle: I move that this House of Delegates adjourn until next year *sine die*. (Motion seconded by Dr. E. V. McCarthy, Chicago, and others, and carried).

The House adjourned *sine die* at 1 P.M.

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For Pictures of  
the  
Annual Meeting  
See pages 151 and 152

DOCTOR, WHEN YOUR PATIENTS ASK...



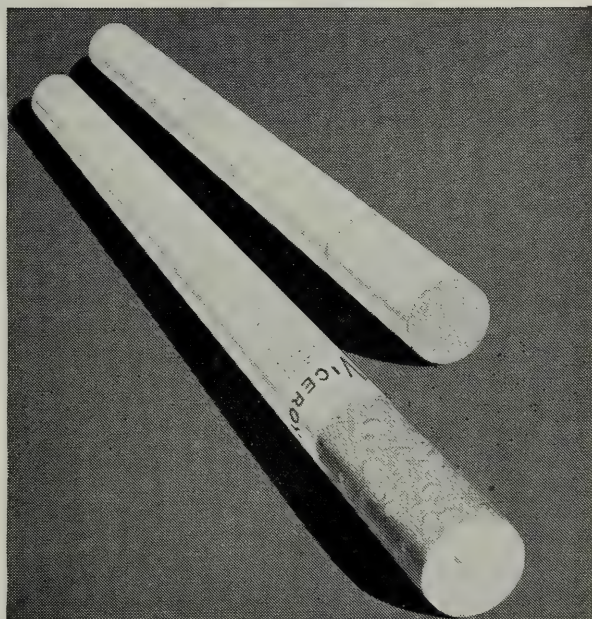
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## BOOK REVIEWS



TEXTBOOK OF MEDICAL TREATMENT Sixth Edition — Edited by: D. M. Dunlop, B.A. (Oxon.), M.D., F.R.C.P. (Ed.), F.R.C.P. (Lond.) Professor of Therapeutics and Clinical Medicine, Univ. of Edinburgh. L.S.P. Davidson, B.A. (Camb.), M.D., F.R.C.P. (Ed.), F.R.C.P. (Lond.), M.D., (Oslo) Physician, H.M. The Queen in Scotland; Professor of Medicine and Clinical Medicine, Univ. of Edinburgh. Sir John McNee, D.S.O., M.D., D.Sc. (Glas.), F.R.C.P. (Ed.), F.R.C.P. (Lond.), F.R.F.P.S. Physician, H.M. The Queen in Scotland; Regius Professor of Practice of Medicine, Univ. of Glasgow. The Williams and Wilkins Co., Baltimore, Md.; 1953, 1023 pages, price \$9.50.

This textbook of medical treatment in its sixth edition since 1939 is concerned with the "Management of the Case". As such, it is pointed out, it is neither a handbook nor an encyclopedia. It attempts to be rather specific in its recommendations regarding therapy and to discard old and unproved methods wherever it seems desirable.

There have been many contributors to this text. The contents are divided into 30 sections.

Most, if not all the subjects, are well presented. There are certain products and materials in general use in this country not mentioned in their text, such as one insulin preparation and one

method of testing urine for glycosuria. Diabetes in general, however, is well presented. Consideration of some types of cardiac diseases, obesity, biliary diseases and others were considered excellent despite the expected differences in opinions regarding an occasional form of therapy.

The reviewer was impressed (if not delighted) by the discussion of the use of vitamins. In decrying the injudicious use of vitamins as drugs the author states: "The prescribing of large doses of water soluble vitamins has at least the safety valve that the body eliminates them rapidly; but imagination boggles at the thought of the pounds worth of unwanted synthetic water soluble vitamins that are now daily lost in human urine."

Psychotherapy in general practice is well presented.

The reviewer is favorably impressed with this textbook. It should be a valuable addition to the physician's library.

G.V.B.

HANDBOOK OF DIFFERENTIAL DIAGNOSIS. Harold Thomas Hyman, M.D. — J. B. Lippincott Company, Philadelphia. — 716 pages \$6.75.

This practical "handy" volume is a complement to standard medical texts.

(Continued on page 38)



footnote

*from the literature*

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H. G. Ravits, *J. A. M. A.*, 148:1005, 1952.

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## BOOK REVIEWS (Continued)

It lends itself readily to quick reference because of its definitive index.

The actual make up of the work groups the symptoms and signs first in divisions of differential diagnosis.

Then the division is arranged with the following specification: An introduction, concisely summarizing back ground material; side headings in bold face type enumerating possible causative mechanisms, usually sub-grouped according to Etiology (infections, allergic, metabolic, etc.,) or predominant system response (circulatory, respiratory, etc.,): A break down of each side head into component diagnostic entities, set in bold face type for emphasis; and a terminal telegraphic description of each clinical syndrome — together with indicated therapeutic tests and suggestions.

This handbook is quite practical. It fills a place in the hands of the general practitioner, or the specialist, or the student.

C. P. B.

## BOOKS RECEIVED

The following books have been received for reviewing, and are herewith acknowledge. This listing should be considered as a sufficient return for the courtesy of the sender. Books that appear to be of unusual interest will be reviewed as space permits each month. Readers desiring additional information relative to books listed, may write the Editor who will gladly furnish same promptly.

ENDEMIC GOITER — The Adaptation of Man to Iodine Deficiency. By John B. Stanbury, M. D., Gordon L. Brownell, Ph. D., Douglas S. Riggs, M. D., Hector Perinetti, M. D., Juan Itoiz, Ph. D. and Enrique B. Del Castillo, M. D. Harvard University Press, Cambridge, Massachusetts, 1954. \$4.00.

THE PHARMACOLOGIC PRINCIPLES OF MEDICAL PRACTICE. A textbook on pharmacology and therapeutics for medical students, physicians, and the members of the professions allied to medicine. By John C. Krantz, Jr., Professor of Pharmacology, School of Medicine, University of Maryland and C. Jelleff Carr, Professor of Pharmacology, School of Medicine, University of Maryland. Third edition. The Williams & Wilkins Company, Baltimore, 1954. \$12.00.

A SYNOPSIS OF CHILDREN'S DISEASES. By John Rendle-Short, M. A., M. B. (Cantab.), M. R. C. P., D. C. H., Senior Registrar, Department of Child

(Continued on page 40)

## "A program of treatment for *chronic ulcerative colitis*...

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1. Rev. Gastroenterology 20:744 (Oct.) 1953; abstract in J. A. M. A., 153:1580 (Dec. 26) 1953.



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## BOOKS RECEIVED (Continued)

Health, Welsh National School of Medicine. Bristol: John Wright & Sons, LTD., London: Simpkin Marshall LTD, 1954. The Williams & Wilkins Company, Baltimore 2, Maryland. \$7.00.

PRACTITIONER'S POCKET BOOKS. (1) PARKINSONISM AND ITS TREATMENT. Edited by Lewis J. Doshay, M. D., M. A., Ph. D. (2) ALCOHOLISM. By Jackson A. Smith, M. D., Director of the Alcoholic Clinic, Jefferson Davis Hospital; Assistant Professor of Psychiatry, Baylor University College of Medicine, Houston, Texas. (3) LOW BACK PAIN AND SCIATICA. By Louis T. Palumbo, M. D., Des Moines, Iowa. 35 illustrations. (4) FLUID AND ELECTROLYTE THERAPY. By Franklin L. Ashley, B. S., M. S., M. D., Assistant Professor of Surgery, University of California Medical Center, Los Angeles, and Horace G. Love, B. S., M. D., Dallas, Texas. J. B. Lippincott Company, Philadelphia 5, Pennsylvania. \$3.00 each.

ANNALS, Vol. 57, Art. 6, "Nutritional Factors and Liver Diseases," by Klaus Schwarz and 58 other scientists. 348 pages, illustrated. \$4.50.

ANNALS, Vol. 58, Art. 3, "The Synthesis and Physical-Chemical Properties of New Aromatic Amidines," by Martin Kuna and M. J. Kopac. 32 pages. \$1.00.

ANNALS, Vol. 59, Art. 1, "Reserpine (Serpasil) and Other Alkaloids of Rauwolfia serpentina; Chemistry, Pharmacology, and Clinical Application," by Frederick F. Yonkman and 34 other specialists. 140 pages, illustrated. \$3.00.

A PRIMER OF PULMONARY FUNCTION. By Harold Guyon Trimble, M. D. and James Kieran, M. D., Oakland, California. Printed through the cooperation of California Tuberculosis and Health Association.

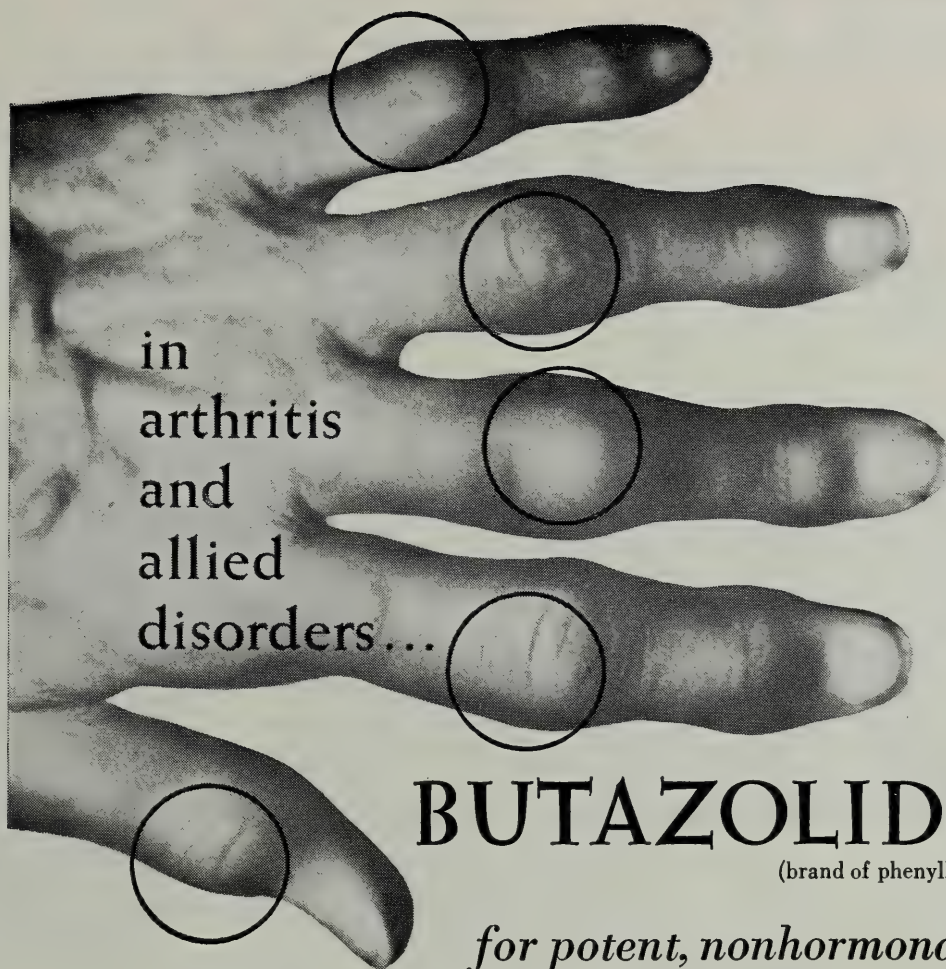
RECENT ADVANCES IN CARDIOVASCULAR PHYSIOLOGY AND SURGERY. A symposium presented by The Minnesota Heart Association and the University of Minnesota. September 14, 15 and 16, 1953, University of Minnesota, Minneapolis.

A CURRICULUM FOR SCHOOLS OF MEDICAL TECHNOLOGY. Editor: Israel Davidsohn, M. D., Professor of Pathology and Chairman of Department, Chicago Medical School, Associate Editor: Kurt Stern, M. D., Director, Blood Center of Mount Sinai Medical Research Foundation and Hospital. Third Edition. Recommended by the Board of Registry of The American Society of Clinical Pathologists, 1953.

GLANDULAR PHYSIOLOGY AND THERAPY. Prepared under the auspices of the Council on Pharmacy and Chemistry of the American Medical Association. Fifth Edition. Completely revised and rewritten. J. B. Lippincott Company, Philadelphia, London and Montreal. \$10.00

NEWER CONCEPTS OF THE CAUSES AND TREATMENT OF DIABETES MELLITUS. Proceedings of the symposium on diabetes sponsored by the New York Diabetes Association and held at Memorial Hospital and the New

(Continued on page 42)



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\*MacKnight, J. C.; Irby, R., and Toone, E. C., Jr.: *Geriatrics* 9:111 (Mar.) 1954.

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## BOOKS RECEIVED (Continued)

York Academy of Sciences, New York City, October 8, 1953. The National Vitamin Foundation, Incorporated, 15 E. 58th Street, New York 22, New York. \$2.50.

**ARTHRITIS AND RHEUMATISM.** The Diseases and Their Treatment. By Charles LeRoy Steinberg, M.D. Director of Arthritis Clinic and Senior Attending Physician in Medicine, Rochester General Hospital. With five contributors. Springer Publishing Company, N. Y., N. Y. \$10.00.

**PRACTICAL FLUID THERAPY IN PEDIATRICS.** By Fontaine S. Hill, M.D., Assistant Professor of Pediatrics, University of Tennessee College of Medicine, Memphis; Staff Member of the John Gaston Children's Hospital and the LeBonheur Children's Hospital. 275 pages. 20 figures. W. B. Saunders Company, Philadelphia and London, \$6.00.

**BEYOND THE GERM THEORY.** The roles of deprivation and stress in health and disease. Iago Galdston, M.D., Editor. A New York Academy of Medicine Book. Published by Health Education Council, Number 10 Downing Street, New York 14, New York. \$4.00.

**PERIPHERAL CIRCULATION IN MAN.** Editors for the Ciba Foundation—G. E. W. Wolstenholme, O. B. E., M. A., M. B., B. Ch., and Jessie S. Freeman, M. B., B. S., D. P. H. Assisted by Joan Etherington. 72 illustrations. Little, Brown and Company, Boston. \$6.00.

**A. M. A. FUNDAMENTALS OF ANESTHESIA.** Prepared under the Editorial Direction of the Consultant Committee for Revision of Fundamentals of Anesthesia, a publication of the Council on Pharmacy and Chemistry of the American Medical Association. Third edition. 270 pages. 89 figures. W. B. Saunders Company, Philadelphia and London, \$6.00.

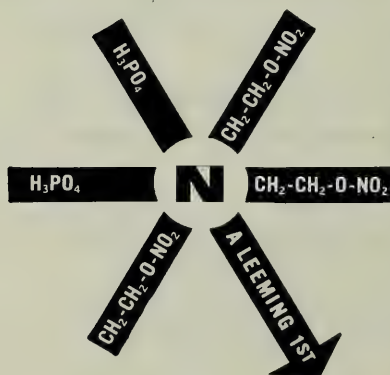
**FIFTY YEARS OF MEDICINE.** An expanded version of the Harben Lectures delivered at the Royal Institute of Public Health and Hygiene, December 1952. By Lord Horder, G.C.V.O., M.D. F.R.C.P. Philosophical Library, Inc., 15 East 40th Street, New York 16, New York.

**THE DEAF AND THEIR PROBLEMS.** A Study in Special Education. By Kenneth W. Hodgson, M.A., (Cantab.) With a preface by Sir Richard Paget, Bart. Fellow of the Physical Society, etc., Author of "Human Speech". Philosophical Library, New York. \$6.00.

**THE ATOM STORY.** The Story of the Atom and the Human Race. By J. G. Feinberg, M.Sc., with illustrations by Lewis and a foreword by Frederick Soddy, F.R.S. Philosophical Library, New York. \$4.75.

**NEW AND NONOFFICIAL REMEDIES** — Containing descriptions of the articles which stand accepted by the Council on Pharmacy and Chemistry of the American Medical Association on January 1, 1954. J. B. Lippincott Company, Philadelphia, London and Montreal.

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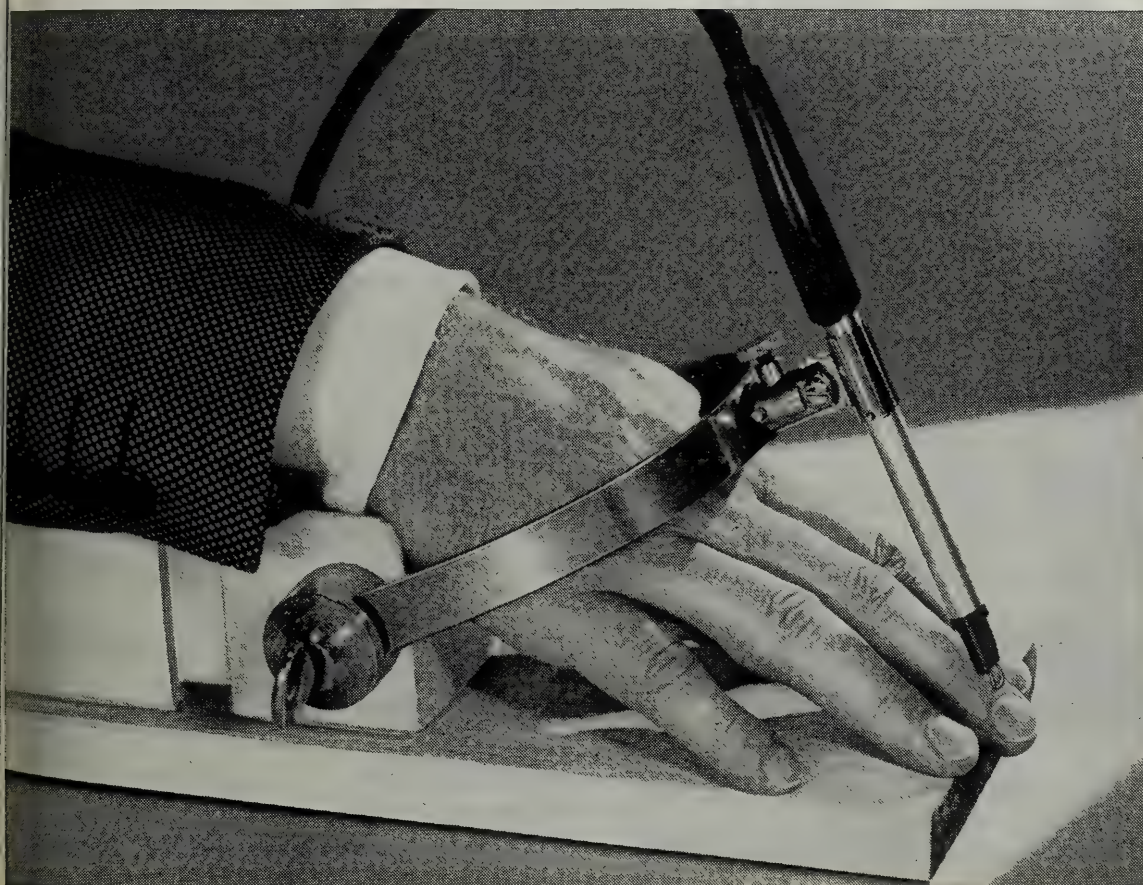
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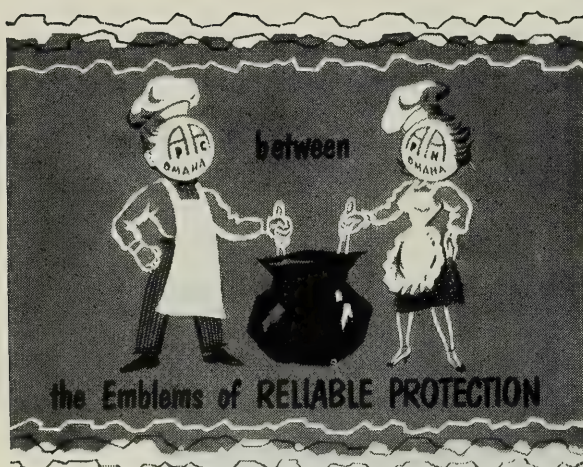
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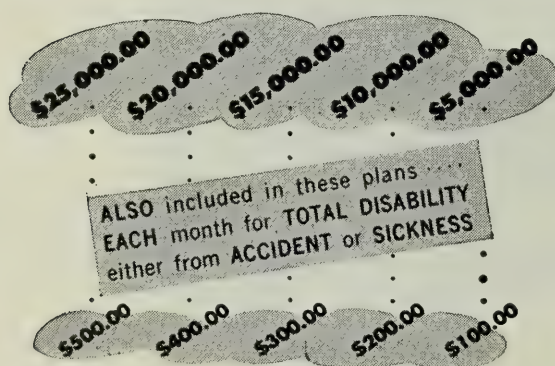


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## CAUSE OF SUDDEN DEATH

Moritz and Zamcheck reviewed 1,000 cases of sudden death in apparently healthy young soldiers between the ages of 18 and 40 during the period from 1942 to 1946. A review of 800 cases yielded five principal categories. The first was heart disease. Of 350 cases of heart disease, 300 deaths were due to coronary heart disease. In 91 cases of intracranial hemorrhage, the second category, 61 had ruptured aneurysms. The third category included 110 cases of meningococcemia, some associated with Waterhouse-Friderichsen syndrome. The fourth large group was miscellaneous. Of those cases in the miscellaneous group, respiratory disease contributed the largest number of deaths. There were other isolated causes such as adrenal atrophy, diabetes, hepatitis, pancreatitis, and septicemia. Obscure causes resulted in death in 140 cases, making up the fifth group. Complete autopsies were done. Sections were prepared from every type of tissue and no cause of death was found. Cases were accepted as falling into this group only when the pathologist was competent and after all tissues had been examined and the records were so complete that injury or poison could be excluded. There were still 140 persons in whom there was not found one single change in the body which could be named as the plausible cause of death. *Marvin H. Grossman, M.D., Sudden And Unexpected Natural Death. Texas J. Med., Jan. 1953.*

When I came to consider local government, I began to see how it was in essence the first-line defense thrown up by the community against our common enemies: poverty, sickness, ignorance, isolation, mental derangement and social maladjustment. The battle is not faultlessly conducted, nor are the motives of those who take part all righteous or disinterested, but the war is, I believe, worth fighting, and this corporate action is at least based upon the recognition of one fundamental truth about human nature: we are not only single individuals, face to face with eternity and our separate spirits; we are members one of another. Winifred Holtby, "South Riding", quoted in European Conf. on Health Education of the Public, London, England, April 10-18, 1953.

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\*Aaron, H.:  
*Weight Control*,  
Consumer Reports  
17:100 (Feb.) 1952.



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## ASTHMA AND ALLERGY

The author takes every opportunity to inveigh against a common current mistake in the diagnosis of asthma. It is assumed by some that most cases of asthma can be grouped as "extrinsic," that is, due to sensitivity to external causes; or as "intrinsic," nonallergic, due to causes within the patient, notably infection. It is indeed true that in older asthmatic persons, infection is increasingly in the picture, aided and abetted by poorer circulation, lowered resistance, and beginning bronchiectasis. Chronic cough, purulent sputum, at times leucocytosis, and mild degrees of fever are much in evidence. A further cause for error is supplied by the lessening reactivity of the skin as people grow older, until negative reactions are obtained to substances which still cause symptoms in the bronchial tree. All of this leads to the serious error of assuming that asthma in the aged is rarely due to allergy but usually is "intrinsic" and infectious. Rackemann has claimed that "extrinsic asthma rarely begins after the age of 45. This is grossly in error. An allergic factor,

if properly sought for, can be found in the majority of elderly asthmatic persons. Even in those whose asthma begins at 70, the clew to the allergic factor is often supplied by a history of other allergic reactions, especially allergic rhinitis, that go back to early youth. That infection plays a frequent and important role in the asthma of the elderly is not denied, but that it is solely responsible is seriously challenged. *Richard A. Kern, M.D., The Management Of Allergic Patients. California Med., Oct. 1953.*

Tuberculosis in the population of any area in the world cannot be brought under complete and lasting control as long as there exist other communities where the disease is rampant and where death rates are high. When we have accomplished the apparently complete control of tuberculosis in our own area we must concern ourselves with the removal of the necrotic areas which block the complete eradication of the disease in the total population. *John H. Skavlem, M.D., NTA Bulletin, June, 1954.*

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## COMPLICATIONS OF R.F.

Acute rheumatic fever is regarded as a collagenous degeneration which localizes selectively in the heart. The changes may be found in many other organs, as shown by the arthritic, dermal, serosal, intestinal, and pulmonary manifestations of the disease. In the acute fulminating form of the disease, pulmonary complications are reportedly found in as high as 50 per cent of the cases. "Rheumatic pneumonitis" has no specific diagnostic features in our experience. Pericarditis is not uncommon. The involved joints tend to show only articular and periarticular swelling. Rheumatoid arthritis frequently is complicated by myositis, neuritis, and arteritis as demonstrated in 70 per cent of muscle biopsies by Traut and Campoine. Traut also stated that the biopsies showed aggregates of lymphocytes, epithelioid cells, and plasma cells somewhat similar to those in dermatomyositis, lupus erythematosus, and scleroderma. Pericarditis is the only unusually frequent cardiac complication, being especially common in juvenile rheumatoid arthritis (Still's disease). In addition, pneumonitis and pleuritis may occur along with the inflammatory reaction in the joints, but is rare. *L. H. Garland, M.D., and M. A. Sisson, M.D., Radiological Aspects Of Collagen Diseases. California Med., Oct. 1953.*

## ACTIVE AND INACTIVE PHYSICIANS

About 93 per cent of the 55,000 physicians participating in the survey reported they were actively engaged in the practice of medicine. Some of these physicians, especially those in the older age groups, worked relatively few hours each week but all devoted a minimum of several hours a week to their profession. Fully retired and no longer in practice were the remaining seven per cent, a proportion somewhat larger than the five per cent reported as retired by the directory of the American Medical Association in 1950. According to this study, no appreciable proportion of physicians enter full retirement until the age of 65; less than one per cent of all physicians under 55 being retired; about 10 per cent of those from 55 to 64; but more than a third of those over 64. *Howard Rusk, M.D., et al., The Work Week of Physicians In Private Practice. New England J. Med. Oct. 22, 1953.*

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Can scientific treatment be compatible with compassion? It has been stated that physicians today know more about medicine than they do about patients. The author believes that in this regard the general practitioner has a place in medical and industrial integration, whether it be local, regional, or governmental including the application of health insurance. He can well be the herald and exponent of good medicine and, at the same time, may be especially useful in psychologically evaluating the patient as a person. The general practitioner can have a special position in the community of industry because of his intimate knowledge of the home environment and living conditions of the worker. In recent years, employers in both large and small plants have taken an increasing interest in the health problems of their employees, which extends to their homes. Claim examiners have long known the relation of home conditions to frequency and severity of injury. As was indicated in the discussions of the Annual Congress of Industrial Health, 1953, industrial medical and health organizations are much more con-

cerned as to the ability of the general practitioner to extend the scope of his service to the health problems of industry. *Orris R. Myers, M.D., The General Practitioner In Industrial Medicine. California Med. Oct. 1953.*

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The knowledge accumulated during the past 75 years has left unsolved many of the problems of the pathogenesis of tuberculosis. Tuberculin tests reveal that even in our communities a very large percentage of the adult population has been at some time infected with tubercle bacilli. Yet, the morbidity and mortality of tuberculosis have decreased by ten- to twenty-fold during the past century. It is obvious, therefore, that while the tubercle bacillus is the specific etiological agent of infection, there are other factors which are responsible for converting infection into tuberculous disease. In other words, the etiology of disease cannot be explained entirely in terms of the etiology of infection. *Rene J. Dubos, M.D., Pub. Health Reports, April, 1954.*

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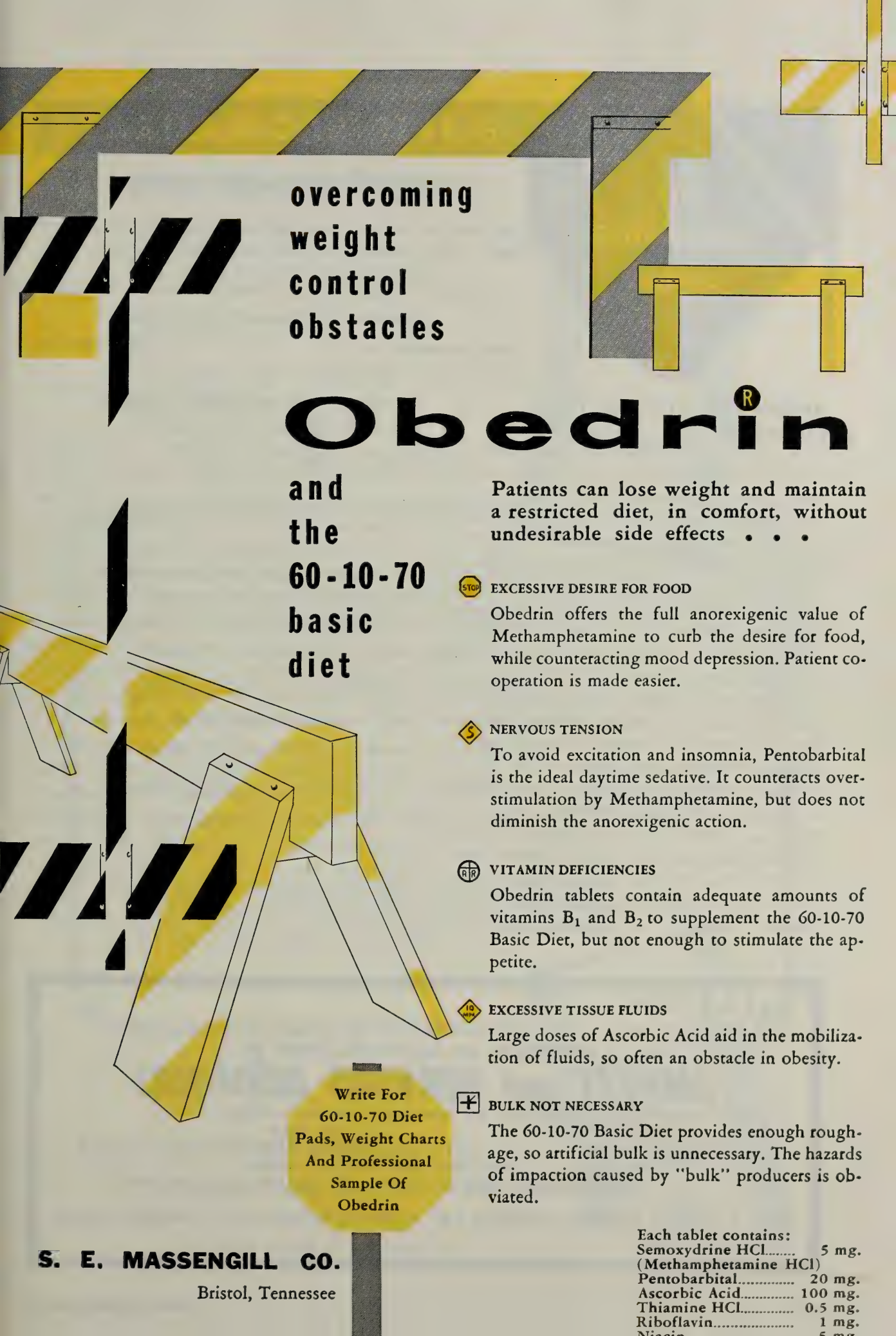
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To a certain extent the waiting room is the display room, the show window of the medical practitioner. Why call it "waiting room" to begin with? Nobody likes to wait. In our studies we found that the patient has a great desire to learn more about his doctor. He wants to establish an emotional relationship with him. What are you doing to help it? For example, there is nothing wrong with having a family album in the waiting room, which would show the patients what you did during your last vacation, introduce him to your family, give him insight and information about yourself as a living, human being and not just a technician in the medical field. What are you doing to make your patients more comfortable while they wait? How old are your magazines? Are cigarettes or candy offered? In what other ways can you help make the waiting period more pleasant? Have you considered slide projectors? *Ernest Dichter, Ph.D., Do Your Patients Really Like You? New York J. Med. Jan. 15, 1954.*

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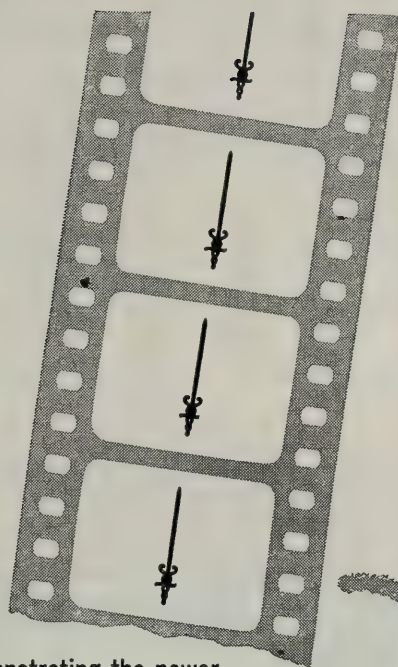
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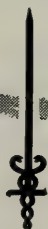
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Health is not to be found apart from the general welfare of the person or the community. Editorial, J.A.M.A., Apr. 24, 1954.

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At one time almost all children in New York City had been infected by the tubercle bacillus before they finished grammar school; now only about 10 per cent are found to be reactors to the tuberculin test by 12 years of age. Haven Emerson, M.D., *NTA Bulletin*, May, 1954.

Public health is found not in the health department but in the mental attitudes, customs, and set of values of the people. People need to become concerned rather with their community as a whole than with public health. Editorial, *J.A.M.A.*, Apr. 24, 1954.

## TRAUMATIC PANCREATITIS

Acute onset of abdominal pain following a blow to the abdomen is typical of traumatic pancreatitis. Pain usually is generalized but greatest in the epigastrium, and it may radiate through or around to the back on either side. Sometimes it is so severe as to cause suspicion of rupture of a hollow viscus. Nausea and vomiting follow and usually are persistent and may be accompanied by manifestations of shock. Upper abdominal tenderness and rigidity are characteristic and usually are followed by distention. Peristalsis is decreased or absent. These symptoms are not diagnostic of pancreatic injury, for injury to viscera in the same general area may cause similar symptoms. However, if only the pancreas is involved, tenderness usually is restricted to a transverse zone across the midepigastrium. If hyper-amylosemia is noted by laboratory study, a diagnosis of traumatic pancreatitis can be made tentatively. It is then necessary to make sure there was no other injuries that, if present, would require laparotomy. *Clarence J. Berne, M.D., and Robert L. Walters, M.D., Traumatic Pancreatitis. California Med. Oct. 1953.*

Volunteers are the foundation on which the tuberculosis movement has been built and achieved its results. Bailey B. Burritt, *NTA Bulletin*, May, 1954.

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**Vol. 106, No. 3**

**September, 1954**

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## **The Present Status of Vagotomy**

**Lester R. Dragstedt, M.D., Ph.D.**

**Chicago**

The present status of vagotomy in the treatment of duodenal ulcer is one of active controversy. There are those who affirm with emotional fervor that the operation is without value. At the other end of the spectrum are the surgeons and physicians at the University of Chicago Clinics, where this operation has practically replaced sub-total gastric resection in the surgical treatment of duodenal ulcer. We prefer vagotomy with posterior gastroenterostomy to sub-total gastric resection for the treatment of duodenal ulcer, because the operative mortality is approximately one-tenth as great, and the percentage of failures is about the same as is secured with a three-fourths resection of the stomach. The patients who get a good result with vagotomy and gastroenterostomy are more nearly normal than are those whose ulcers are cured by sub-total gastric resection. This is due to the fact that the storage function of the stomach has been preserved.

As I reflect on this wide divergence of opinion among good surgeons in this country and abroad, it seems to me that the reasons can be grouped under four general categories. In the first place I am impressed with the fact that surgeons who have not secured good results from the operation almost uniformly describe their procedure as a subdiaphragmatic vagotomy. On the other hand those of us who have continued from the beginning to report good results, invariably describe

it as a supradiaphragmatic section of the vagus nerves. Why should there be a difference when the operation is performed at these two sites. It depends, I believe, on the fact that to eliminate the nervous phase of gastric secretion, all or practically all of the vagus fibers innervating the stomach must be divided. It is difficult or impossible to cut all of the vagus fibers to the stomach if these nerves are attacked below the diaphragm or on the wall of the stomach. In our series it has been possible to secure a complete vagotomy only when the vagus fibers have been divided at the region of the lower esophagus, and before they have branched into the wall of the stomach.

I usually employ a high mid-line or left paramedian incision. It is important to get good exposure, and in some patients it may be necessary to excise the xiphoid cartilage as Saint recommends. The suspensory ligament to the left lobe of the liver is then divided, the lobe pulled over to the right and held in place with a spring retractor. This maneuver exposes the upper part of the stomach, and the Levine tube may be palpated in the esophagus. The diaphragm, about 1 cm. over the middle of the esophageal hiatus, is picked up with forceps, opened with a small incision, and the scissors thrust upward into the mediastinum. By spreading the scissors the opening in the diaphragm may be made large enough to admit two fingers. The index finger is then introduced into the mediastinum over the esophagus, and the esophagus is very carefully separated from surrounding areolar tissue. In this separation it is of the greatest importance

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that the surgeon does not insinuate his finger between the vagus fibers and the esophagus. With a sweeping motion of the index and middle finger, the vagus fibers are picked up with the esophagus and pulled downward into the abdomen. The anterior vagus trunks then come into view on the anterior wall of the lower portion of the esophagus, and the posterior trunk is readily felt against the posterior wall of the esophagus. I make use of finger dissection because palpation helps the surgeon very materially in finding these nerves. In this connection, experience at the autopsy table will be found very rewarding. The main nerve trunks are clamped as high as possible, ligated with non-absorbable suture material, and a segment 2 to 4 cm. in length excised. The esophagus then comes downward more readily, and with a pair of forceps all fibrous stands, blood vessels, or bits of fascia that look or feel like a nerve fiber are picked off. When the operation is finished the lower two inches of the esophagus within the chest presents only the denuded, longitudinal muscle bands.

A second cause for difference of opinion depends upon the selection of cases. When the operation was first introduced in our clinic I employed it as a substitute for sub-total resection on all patients with ulcer disease who were referred for surgical treatment. I believe, however, that a selection of cases suitable for this operation is both possible and wise. Gastric ulcers and actively bleeding ulcers should be treated by resection. Vagotomy and gastroenterostomy is most successful in the treatment of duodenal ulcer that has proved resistant to medical management, or in patients who present the usual criteria indicating surgical intervention for this disease. The great majority of the 870 patients who have had vagotomy and gastroenterostomy in this clinic, have been operated upon because they were unwilling or unable to carry out an adequate type of medical management. They wanted to be free of the self-denial that such management requires.

Measurements of the fasting nocturnal gastric secretion has proved of great value in the selection of patients for surgery, and in postoperative management. The patient is usually given a liquid diet for 24 hours to make sure there is no solid material in the stomach. A flexible rubber tube is introduced through the nose at 9:00

p.m., the stomach is emptied and the sample discarded. Constant suction is then maintained from 9:00 in the evening until 9:00 the next morning. During this time the patient is shielded from the sight, odor and taste of food, and since there is no food in the upper gastrointestinal tract the usual physiological stimuli for gastric secretion are absent. The total volume aspirated is measured, and the free acid concentration determined. If the concentration of free acid is expressed in clinical units, and the volume in liters, the product of the two gives the output of free hydrochloric acid expressed in milliequivalents. Under these circumstances the fasting nocturnal gastric secretion for normal people averages 18 mEq. Duodenal ulcer patients, however, put out an average of 60 mEq. or more than 3 times as much. It is of considerable interest that gastric ulcer patients put out about the same amount of free HCl as is found in normal people.

A quantitative measurement of the free HCl output in the fasting nocturnal secretion is very helpful in selecting patients for vagotomy. For instance, recently a physician consulted me with respect to the advisability of surgical treatment for his duodenal ulcer. He had not had an adequate trial with medical management. On measuring his night secretion I found that he put out not 18 but 358 mEq. of HCl. In view of this enormous nocturnal secretion, I concluded that it was unlikely that any kind of neutralization regime that he could tolerate would be effective. A surgical procedure, either vagotomy or resection, would be required to reduce this excessive secretion. The beneficial effect of vagotomy is largely due to removal of the nervous phase of gastric secretion. After these nerves have been completely divided, the nocturnal secretion falls to below the normal level.

Elimination of the nervous phase of gastric secretion is accomplished by cutting the secretory nerves in the vagus trunks. At the present time this cannot be done without at the same time cutting the motor fibers. Because of this fact it is always necessary to combine the vagotomy operation with a posterior gastroenterostomy of small size, so that when the operation is finished the opening between the stomach and the jejunum is not larger than would admit one finger. A larger anastomosis is apt to lead to the

dumping syndrome in some patients. It is of the greatest importance to place the anastomosis in or very near to the antrum of the stomach. A high-lying gastroenterostomy may result in the stasis of food in the antrum, with subsequent stimulation of gastric secretion from the hormone or antrum phase of stimulation.

It has been our routine practice to place a tube in the stomach two days before the contemplated operation. In an average case the output of free hydrochloric acid in a 12 hour period at night would amount to 60 mEq. A roughly similar figure will be obtained the second night. However, on the night before operation, the patient may put out 90 mEq. of free HCl. The tension concerned with the anticipated surgical procedure seems to express itself in an exaggerated secretion of gastric juice. The tube is left in place in the stomach for 5 days after the vagotomy and posterior gastroenterostomy has been performed. During this period, nightly determinations of the output of acid are made. In an average case the acid output falls to 5 mEq. or less the first night, and may remain at this low level on the second and third night, and rise to 8 or 9 mEq. on the fourth determination. A final determination of the nocturnal secretion is made on the tenth day just before the patient leaves the hospital. A re-check of the nocturnal secretion is made after an interval of 3 to 6 months after the operation, and if at this time the output of free HCl acid is below the level found in normal people we feel confident that the patient will get a good result and will have no further trouble with ulcer disease. On the other hand if we have failed to get a complete vagotomy, the night secretion may have been reduced to the normal level for the first night after the operation, but very promptly thereafter returns toward the amount put out before the operation was performed. Such a patient will give a positive response to insulin

hypoglycemia, indicating that all of the vagus branches have not been divided. The secretory response of the stomach to insulin hypoglycemia has been abandoned as a routine test in favor of quantitative measurement of the nocturnal gastric secretion, as this latter test has been found to be of greater practical value. Decompression of the stomach for 5 or 6 days following operation, usually permits the return of sufficient tone and motility to allow for satisfactory emptying in the presence of the gastroenterostomy. After the decompression period, the patient is permitted to take 30 c.c. of water per hour, and at the end of the day the stomach is aspirated. If no more than 100 c.c. of fluid is obtained, 60 c.c. of water per hour is given the next day. If again the emptying of the stomach is satisfactory, he is permitted a small amount of semi-solid food. Increments are made depending entirely upon satisfactory emptying of the stomach. In our experience this type of management has very largely eliminated stasis in the stomach, attacks of belching and episodic diarrhea.

I advocate this operation because it is sound from the standpoint of the abnormal physiology found in duodenal ulcer patients. Many thousands of such patients are now living in comfort, and free of ulcer disease as a result of vagotomy and gastroenterostomy. Much of their comfort and ability to gain weight is due, I believe, to the fact that it has not been necessary to sacrifice the storage function of the stomach. We are doing the operation with more enthusiasm and satisfaction now than we did 10 years ago. Our experience has served to give us more confidence in the procedure. If I had a duodenal ulcer myself that proved refractory to medical management, I would not have a three-fourths or seven-eighths gastric resection unless the more conservative operation had failed.

# Treatment of Convulsions

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The treatment of convulsions in children becomes increasingly difficult as we continue our studies of the causes. Investigations into the etiology of convulsions especially with the electroencephalograph make the classification more and more detailed and complex as we find more etiologic factors. Except for the immediate, emergency, symptomatic treatment the selection of the proper drug demands as much study and discrimination as does the selection of the correct antibiotic and electrolyte. The wrong choice may not only fail to produce the desired result but it may precipitate or aggravate serious and even fatal reactions.

The general practitioner and the pediatrician must have a basic understanding and familiarity with the more common causes of convulsions before they are in positions to prescribe proper treatment. At times a most complete study, including expert encephalography, may reveal a correct diagnosis for which there may be no specific anti-convulsant. Treatment may then become a process of trial and error. However, when facilities are available and circumstances permit the child presented for treatment of convulsions must be given a complete study. This must always begin with as detailed a family history as it is possible to obtain. Inasmuch as Lennox,<sup>2</sup> the Gibbs,<sup>3</sup> Kimball<sup>4</sup> and others<sup>5</sup> have established the well known clinical fact that idiopathic or genetic epilepsy, or a tendency to convulsions is an inherited disease just as are diabetes, hemophilia, and many others, a knowledge of a convulsive tendency in the family provides a useful basis or lead in the study. Next, the past history, particularly of infantile convulsions, age of onset, time of appearance, type and character of seizures yields further information.

With the increasing specificity of the newer drugs, and in some instances, with the antagonistic effects toward other manifestations or closely related components of the same disease entity it becomes essential to determine, if possible, the

type and etiology of the convulsive disorder before planning treatment.

## DIAGNOSIS

If we divide childhood into four age periods we find that convulsions in the infant under one year of age are usually due to the residual of a brain injury at birth. This may be hemorrhage, gross or petechial, anoxia, edema, etc. From one to three years of age most of the convulsions are associated with fever<sup>6</sup> or with acute infections. From three to ten years the convulsions are due to infections or to idiopathic epilepsy. From ten to sixteen years of age most convulsions are due to epilepsy.<sup>7</sup> With these conditions in mind the physician can make a provisional presumptive diagnosis and start treatment while he continues his study of the case. However, even with a classical history and with typical convulsions it must be realized that the diagnosis is made on subjective evidence. The diagnosis of idiopathic or genetic epilepsy is made by exclusion, hence, the designation idiopathic.<sup>8</sup> Even those who challenge or reject the term have no substitute for the word idiopathic which connotes the whole syndrome or disease entity.<sup>9</sup> If the services of a reliable and competent electroencephalographer are available they should be utilized for the next step in the diagnostic study. If the record is positive and specific the diagnosis may then be confirmed with objective evidence. It is also easier to get complete cooperation and rigid adherence to a treatment schedule.

## TREATMENT

There is no panacea or anti-convulsant compound which is effective in the control of all convulsions nor of all manifestations of epilepsy. Beware of extravagant claims and exaggerated results reported with new drugs, particularly those announced in newspapers or introduced in popular magazines. The closest approximation to a universal, safe anti-convulsant is phenobarbital. For all major seizures at all ages this drug should be given first trial in adequate dosage. It is almost a specific in grand mal epilepsy. It may be used for diagnostic as well as therapeutic trial. If phenobarbital in tolerance

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doses as the first drug used does not control the major convulsions they are probably not due to idiopathic or genetic epilepsy.<sup>10</sup> Phenobarbital is a safe drug in all ordinary doses and I have never seen increased tolerance or habituation in children. Trade names for this compound, such as "Luminal",<sup>R</sup> "Mebaral",<sup>R</sup> etc do not increase its effectiveness. In children of all ages with major convulsions phenobarbital is the first drug of choice. In infants and young children the drug is best administered as a crushed tablet in milk, jelly or syrup. The elixir is too sharp and bitter unless the taste is disguised.

If phenobarbital in tolerance dosage is effective but causes drowsiness or stupor, amphetamine may be used to counteract and even complement the drug. If phenobarbital in adequate dosage does not control the major convulsions in infants and children, Gemonil,<sup>R</sup> (5-5-diethyl-1-1-methyl-barbituric acid) another barbiturate, should be tried. This drug is an effective anticonvulsant which does not have the sedative or depressing effect sometimes observed with phenobarbital.<sup>11</sup>

Major convulsions in infants and young children which resist phenobarbital and Gemonil<sup>R</sup> should be treated with phenacemide (Phenurone.)<sup>R</sup> This drug introduced in 1948<sup>12</sup> is the first compound found effective in some of the cases of akinetic seizures or nodding spasms in infants.<sup>13</sup> It is also the first drug found effective in psychomotor or psychic equivalent or "temporal lobe" epilepsy.<sup>14</sup> The widest use, however, will be in the treatment of major convulsions of organic cause. Phenacemide is a toxic compound (phenacetylurea) which occasionally depresses the bone marrow and damages the liver. In older children and in adults it may produce psychotic reactions. When phenacemide is used it is absolutely essential that the blood count be checked every month, and that liver function tests be done whenever there is any suggestion of liver damage. I have seen only four cases of leukopenia in 175 patients treated with phenacemide in a five year period. This is a much lower incidence of side reactions than that observed with the use of the hydantoin compounds. It must be realized that when phenobarbital in tolerance dosage fails to control seizures that heroic measures may be necessary and hazards must be accepted. Repeated major

convulsions produce more organic cerebral damage and deterioration than do anticonvulsant drugs.

The hydantoin compounds, Dilantin-sodium,<sup>R</sup> Diphenoin,<sup>R</sup> and Mesantoin,<sup>R</sup> should be considered last in the treatment of chronic recurrent convulsions which have not responded to the other anticonvulsants. These drugs are apparently more effective in adults than I have found them to be in children. When they are given in effective dosage the hydantoins produce disequilibrium, vertigo, irreversible hypertrophy of the gums in a high percentage of cases. Fatalities have been reported following the use of these compounds.

When phenobarbital and phenacemide fail I prefer to use combinations before resorting to the hydantoins. I begin with phenobarbital and phenacemide or phenobarbital and amphetamine or metharbutal (Gemonil)<sup>R</sup> and phenacemide or phenacemide and amphetamine. Any or all of these combinations may be supplemented with the bromides as a last resort.

TABLE 1  
IMMEDIATE TREATMENT OF CONVULSIONS  
IN CHILDHOOD

1. Phenobarbital sodium subcutaneously, intramuscularly, or intravenously every 6 hours until desired effect is produced. Continue by mouth.
2. Magnesium sulfate by mouth or by rectum in 50% solution, intramuscularly in 25 to 50% solution, or intravenously, slowly, in 20 to 25% solution.
3. Paraldehyde by mouth, by rectum, intramuscularly or intravenously.
4. Chloral hydrate by mouth or by rectum.
5. Chloroform or vinyl ether by inhalation.
6. Oxygen, when convulsion prolonged.
7. Tribromethanol (avertin<sup>R</sup>) by rectum.
8. Spinal fluid drainage and air replacement. X-ray of skull for diagnosis.
9. Thiopental (pentothal<sup>R</sup>) sodium, continuous intravenous drip.
10. Absolute rest for 10 days.

The immediate treatment of a child in convulsions is detailed in Table 1. The treatment of major convulsions of organic origin is listed in Table 2.

The treatment of akinetic seizures or nodding spasms, observed most frequently in infants from 6 months to 3 years of age, should be first attempted with phenacemide. Contrary to some

TABLE 2  
TREATMENT OF MAJOR SEIZURES

1. Phenobarbital. Increase dose to tolerance if necessary.
2. "Gemonil" (5,5-dimethyl-1-methylbarbituric acid)
3. Phenacemide (Phenurone<sup>®</sup>) check blood.
4. Bromides

reports I have found these seizures to be resistant to treatment and to produce rapid deterioration and often death. They should be treated seriously and intensively. If phenacemide is not effective, Gemonil should be tried. The hydantoins are then in order. If all anti-convulsants fail a pneumoencephalogram should be done for diagnostic as well as therapeutic reasons.

#### IDIOPATHIC EPILEPSY

When the diagnosis of idiopathic or genetic epilepsy has been made and organic cerebral lesions have been excluded, preferably with the electroencephalograph, it is imperative that the type or types be determined if possible. This is essential because some of the anti-convulsants are not only highly specific but because they have antagonistic actions toward the other components of the disease entity. For instance, phenobarbital is highly effective in controlling grand mal but has absolutely no effect on petit mal seizures. Tridione<sup>®</sup> or Paradoine<sup>®</sup> will control about one third of the cases of petit mal but they have no control of major seizures and may even precipitate them or produce status epilepticus. Phenobarbital may aggravate the behavior disorders in psychomotor epilepsy or in psychic equivalents.

The only treatment which is effective in all types or components of epilepsy and which is safe and harmless and will not aggravate or precipitate any part of the syndromes in the ketogenic diet.<sup>15</sup> This must always be preceded by a preliminary period of ten to fourteen days of fasting in a hospital. If the fast does not control or stop the seizures the diet will not be effective and need not be started. If the fast becomes effective after four or five days it should still be continued for at least ten, better fourteen days after which the diet may be started abruptly. It consists of 15 Gm of carbohydrate daily, 1 Gm of protein per kilo of body weight and the remaining caloric requirement in fat.<sup>16</sup> The initial diet may be calculated on the basis of 33 calories

per kilo. Further modifications must be made to keep the weight near normal for age and height. The details have been outlined elsewhere.<sup>17</sup> The largest series of private patients with epilepsy treated the longest time and with the best results reported 51% free of seizures and 25% much improved.

If the diet is not practical or possible the manifestations of the disease syndrome must be treated specifically. The child with grand mal seizures should be given phenobarbital in adequate dosage and to the limit of tolerance if necessary. The drug should be given every 12, 8 or 6 hours as necessary to anticipate the seizures. If phenobarbital is not effective or if undersirable reactions occur, the drug may be replaced with metharbital or Gemonil.<sup>®</sup> If both of these fail, phenacemide or phenurone<sup>®</sup> should be tried under careful supervision. When anti-Convulsant medication is given every 6 or 8 hours the intervals must not be any greater than that of the effectiveness is lost. Investigations are in progress to determine the value of enteric coated anticonvulsants which may be given at bedtime in the hope that the effect will continue until the child awakens naturally in the morning. This may allow for larger dosage than can be tolerated through the day.

The most effective treatment for petit mal epilepsy has proven to be the ketogenic diet. About half of the children who start with petit mal have a grand mal component and usually develop this manifestation later if untreated. This also makes the ketogenic diet the treatment of choice. It must be realized that what appears to be clinically petit mal may be minor manifestations of major seizures and these may be of organic origin. The drug treatment of petit

TABLE 3

Diagnosis (Final)	Cases
Idiopathic epilepsy .....	66
Cerebral birth injury residual, convulsions .....	35
Convulsions .....	146
Encephalitis with convulsions .....	17
Brain hemorrhage residual with convulsions .....	8
Cerebral dysgenesis .....	5
Cerebral anoxia .....	2
Rheumatic fever .....	2
Miscellaneous .....	21
Total .....	302
Taken from J. Ped. 41:536 (Nov) 1952	

mal epilepsy should begin with Tridione (Trime-thadione). This drug should always be given in combination with phenobarbital or Gemonil to control or prevent possible grand mal attacks. The drug may have serious toxic side effects and may even be fatal, therefore, the patient should have a blood count in two weeks and monthly after starting the preparation. If Tridione is not effective, Paradione (paramethadione) may be used. If neither of these drugs is effective and particularly if there is reason to suspect that the petit mal may be of organic origin, phenacemide or phenurone may be used with the precautions noted above. A new succinimide compound "Milontin<sup>R</sup>" has been reported to be effective in the treatment of some cases of petit mal and it is being further investigated at this time. Thus far no serious toxic effects have been observed following its use. If all of these drugs fail, the ketogenic diet must be used as a last resort. It must be realized that all of the anti-convulsant drugs provide only symptomatic treatment and not "cures".

The treatment of febrile convulsions which usually occur in children under 3 years of age consists in the administration of the anti-convulsants and then hydrotherapy or the use of anti-pyretics to control the temperature. These convulsions which constitute a separate entity except as described elsewhere must be given serious consideration and carefully studied, since 22% of the so-called febrile convulsions are due to epilepsy.

Once the convulsions are under control without serious side reactions the drug or drugs should be continued unchanged until the child has been

entirely free of seizures for at least one year. If possible, an electrogram should be obtained to detect subclinical activity.

### CONCLUSIONS

In conclusion, it is advisable to make every effort to determine the basic cause of a convulsion before considering treatment. The anti-convulsant compound should be selected on the basis of the suspected lesion or disorder. The drugs of choice may be listed in order

1. Phenobarbital because of effectiveness and safety.
2. Metharbutal or Gemonil.<sup>R</sup>
3. Phenacemide or Phenurone.<sup>R</sup>
4. The hydantoins.
5. Bromides.

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# Treatment of Prolonged Labor

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The bane of obstetrics is prolonged labor. The incidence occurs in two to four per cent of all labors, and is defined as true labor persisting over 24 hours. It is considered a pathological exception in which time is not the healer. Watchful intelligent expectancy has been the dictum but not the solution. It is an entity that produces a high incidence of maternal and fetal complications. Many hidden obstructing factors are discovered late in labor. There is a tendency for the obstetrician to express optimism before a true knowledge of the circumstances has been uncovered. As a result the parturient hopes of an early delivery are repeatedly shattered. An approach to the patient's emotional and physical well being is presented together with recent medical concepts in management.

The most common complication of labor is uterine inertia which may be defined as any defect in the power, length, or frequency of uterine contractions. If the contractions are feeble, transient, or infrequent a labor which otherwise might have been normal, may continue for days, to the discomfort and even exhaustion of the patient.

Recent concepts as to the cause of uterine inertia do not differ remarkably from the past. Landis<sup>1</sup> in his obstetrical treatise published in 1885 on the management of labor, emphasized the irregularities of uterine contraction in prolonged labor was due to altered physiology. With the aid of a multi-channel strain gage tokodynamometer Reynolds<sup>2</sup> and co-workers<sup>3</sup> in 1948 revealed through experimental work on the human uterus that there is a gradient of rhythmic contractions which originates from the fundus of the uterus downward into the passive segment and cervix. A fault in the mechanism causes a dysrhythmia with independent strong contractions in the various uterine segments interfering with normal retraction of the cervix and descent of the fetus. Congenital anomalies such as the bicornate uterus will disturb uterine dynamics as well as leiomyoma, faulty innervation, debili-

tating conditions, and the endocrine disturbances.

Other factors responsible for prolonged labor are: abnormal positions of the uterus, such as anteversion with a pendulous abdomen; polyhydramnios, malpresentations, generally contracted pelvis, anomalies of the cervix and vagina, old primigravida, constriction ring, and a full rectum and bladder.

Before any treatment of prolonged labor is instituted the criteria of true labor as defined by Eastman<sup>4</sup> must be fulfilled. There must be evidence of progressive effacement and dilatation of the cervix despite the poor pains. If a primigravida with poor pains is less than 3 cm dilated it is best to consider the case one of false labor and give no treatment. The same general rule applies to the multiparae less than 4 cm dilated.

The treatment of prolonged labor must first be prophylactic in the form of instructive prenatal training, early recognition of the condition and cooperative attendants in the labor room.

Prenatal training is directed toward natural childbirth. A series of lectures may be attended by both the patient and her husband. Exercises are taught after the first trimester when the danger of abortion has been the greatest and the patient has been most uncomfortable from nausea and vomiting. Educational films are shown from the development of the child to the actual delivery in practicing natural control. Thus the patient, properly educated, no longer fears the unknown and is able to relax, releasing tensions psychogenic in origin that impede the normal physiology of labor. It therefore eliminates the artificial means of excessive sedation to remove the inhibitions of labor.

Early signs of prolonged labor may be recognized by the physician who remains at the bedside palpating uterine contractions. If true labor has been in progress for eight hours with no change in cervical dilatation of 3 cm for the primigravida and 4 cm for the multiparae, and the contraction interval is over four minutes, of only 45 seconds duration with ability to indent the uterus with the finger at the acme of contraction prolonged labor should be suspected.

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An asymmetry of the uterus may reveal itself for the first time with active contraction indicating a bicornate or arcuate type of uterus.

Active treatment is directed by the disclosure of the obstructing forces. A sterile vaginal examination at the end of 12 hours aids in evaluating the consistency of the cervix and its dilatation, the condition of the amniotic sac; station and position of the presenting part; amount of caput formation and molding; plus a re-evaluation of the osseous structure including the mid plane. The membranes may be artificially perforated at the time of the sterile vaginal if the cervix is dilated to 5 cm and the presenting part engaged. Occasionally when in labor rupturing the amniotic sac will release the fluid tension and allow the uterus to relax more effectively between contractions. Consequently the uterine contractions are more forceful aiding in properly directing the force in the plane of the birth axis.

Faulty contractions are frequently the result of a circular constriction ring. Rudolph<sup>5</sup> describes a circular constriction in any portion of the uterus which divides it into two parts. The segment above the ring is tonic and tender during a uterine contraction. The part below the ring is flaccid and neither tender or painful during a contraction. It hangs loosely over the presenting part. No descent is possible because of the viselike grip around the fetus impeding its progress. Rupture of the uterus will not occur. A sterile vaginal examination may give the first clue when the presenting part does not fit snugly against the cervix. The ring may be palpated by intrauterine examination over the presenting part. Any attempt at delivery with complete dilatation will only irritate the constriction and further entrap the fetus.

Therapy is directed towards relaxation of the constriction ring by amyl nitrite, adrenalin 8 minims intramuscularly, and finally ether inhalations. When the anesthesia or drugs fail to relieve the constriction ring and fetal distress is marked a cesarean section is required.

A persistent edematous anterior lip of the cervix indicates most likely an occiput posterior. The asynclitism in descent interferes with retraction of the cervix over the fetal skull. The edematous lip may become impinged against the symphysis by inadvised bearing down of the patient leading to pressure necrosis and spontane-

ous amputation of the anterior lip. The condition of the cervix is recognized either on rectal or vaginal examination. If the edematous anterior lip is obstructing progress it is gently pushed over the fetal head as the patient experiences a contraction. If spontaneous rotation does not occur the occiput may deliver as a persistent posterior. An arrest in rotation in the absence of maternal or fetal distress may be conservatively managed regardless of the dictum that interference is recommended after two hours of second stage. Failure of labor to terminate spontaneously after 4 hours in the second stage will lead to first manual rotation and extraction, or the Scanzoni Maneuver.

X-ray pelvimetry with fetal profile should be done after 24 hours of true labor. The mid plane of the pelvis, and unsuspected source of interference, must be accurately measured. Pelvimetry is not only indicated for the primigravida but also the multipara in prolonged labor. False security is sometimes maintained with the multipara who has delivered small babies previously. An unrecognized cephalopelvic disproportion may exist in future pregnancies with threatened rupture of the uterus.

Infection can be controlled with judicious use of antibiotics. Temperatures are recorded every four hours. Rectal examinations should be at a minimum since they potentially infect the uterus by forcing the vaginal flora into the gaping cervix.

Proper fluid balance is essential. The intake must be at least 2000 cc over a 24 hour period but this is influenced by environmental temperature as well as presence of fever which requires more fluids to balance the rapid loss. Nourishment in the form of glucose maintains the normal chemical balance in muscular contractions.

Heavy sedation with morphine after 24 hours of labor permits at least four to six hours of rest. Morphine derivatives are not adequate for complete relief. Sedation in milder forms, i.e., Meperidine (Demerol), Prisilidine (Nisentil), methadone (Dolophine) or the barbiturates affects an analgesia and a degree of amnesia essential to the hyperesthetic patient. In normal labor sedation has no direct effect on the progress, but in faulty labor progress may stop thus aggravating an already abnormal condition. Seda-

tion also slows the emptying time of the stomach interfering with nourishment and fluid balance especially if the patient suffers nausea and vomiting.

In recent years intravenous oxytocin (pitocin) has been advocated in protracted labor since it maintains a constant blood level, is rapidly eliminated, and can be readily controlled. Extreme precaution is emphasized before administration. This is a powerful oxytoxic and its abuse has been responsible for many tragedies involving both mother and infant. Many authorities still oppose its use before the birth of the child. However, serious hazards in the form of maternal exhaustion, intrapartum infection, and traumatic operative delivery in advanced uterine inertia presents a problem that may be remedied by judicious and cautious use of posterior pituitary hormone.

There are definite contra-indications to pitocin, such as, cephalo-pelvic disproportion, constriction ring, fetal distress, grand parity of over four children, malpresentations, breech presentations and a history of sensitivity to pitocin. It should be given only for uterine inertia and never before the patient has had adequate rest.

Pitocin 10 minims is diluted in 1000 cc of five per cent dextrose either in saline or distilled water and is administered at the rate of 200 cc per hour. The rate of flow is influenced by the interval between contractions and duration. The initial response may be tetanic contracture which requires either stopping the flow or decreasing its rate. Ether inhalation is available to relax the uterus if tetany persists longer than two to three minutes or there is evidence of fetal distress. Once good contractions are established the intravenous pitocin is continued since labor will again slow up if the oxytoxic is discontinued. Even after labor is completed the pitocin must be continued to prevent hemorrhage from an atonic uterus. If the attempt to stimulate progress fails with pitocin after four to six hours no further trials are suggested. There is probably unrecognized cephalo-pelvic disproportion or cervical dystocia. There have been 10 per cent failures reported in uterine inertia. The incidence of cesarean sections and mid forceps extractions has been reduced with this regime.

A vital question now presents itself. How long should we permit prolonged labor to continue?

The answer may be determined by the condition of the mother and infant. If both conditions are good, labor may be allowed to continue with assistance only when complete dilatation has been attained.

Interference is advised in the presence of either maternal or fetal distress and the method of delivery must be carefully considered. When the patient is a primigravida it is difficult to accurately estimate fetal size and with no aid from previous capabilities the proportions between the fetal skull and birth canal must be determined. The position of the fetus, estimated size, cervical dilatation and station of descent are important factors. If vaginal delivery is contemplated before complete dilatation Dührsens incisions are done preferably at 8 cm dilatation. Manual dilatation leads to uncontrollable lacerations and is therefore not recommended. The type of forceps employed depends upon the skill and training of the obstetrician. Damage to both maternal soft parts, and fetus must be avoided. If vaginal delivery presents serious risk to either mother or fetus a cesarean section is performed. Failed forceps have occurred due to unrecognized disproportion and labor has been successfully terminated with cesarean section.

The practitioner should not attempt a brutal vaginal delivery if he realizes his error in diagnosis. A few attempts at well applied forceps should be made and if fetal impaction from malpresentation or bony disproportion is not being overcome the safest and wisest procedure is to discontinue the attempt at extraction and do a cesarean section. Kobak<sup>6</sup> has shown that a cesarean section with our present day antibiotics can be performed even in the presence of infection. This knowledge has prevented many obstetrical invalids and salvaged more infants.

#### SUMMARY AND CONCLUSIONS

The obstructing factors are generally recognized late in protracted labor. The practitioner should personally examine the character of uterine contractions in the early hours of labor and outline supportive management. Sterile vaginal examinations are performed too infrequently resulting in failure to determine the true picture of labor. X-ray pelvimetry is incomplete if the mid plane measurements are not revealed.

A careful evaluation of hydration should be made. Adequate rest with heavy sedation is

preferred. Excessive analgesics may be avoided if proper prenatal education is instituted to eliminate tension there by maintaining a natural control of uterine physiology.

Intravenous oxytocin, although hazardous, is definitive therapy for uncomplicated uterine inertia. Its use for postpartum uterine atonia following prolonged labor is recommended.

The choice of interference considers the safety of both mother and infant. Brutal vaginal delivery with sacrifice of the fetus is to be condemned when cesarean section offers the safest approach.

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## Obscure Gastrointestinal Hemorrhage

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Hemorrhage from the gastrointestinal tract, either the massive acute or the less severe recurrent type, follows common patterns made evident by a careful history, physical examination, and routine laboratory procedures. There remains, however, a significant number of cases with obscure etiology after this study. By definition, therefore, obscure gastrointestinal hemorrhage may be described as that hemorrhage not defined as to etiology by routine history, physical and laboratory examinations. Various authors<sup>1,2,3</sup> have reported hemorrhage of obscure origin as follows: Costello, 1.3%; Rivers, 2%; White, 5%; Jankelson, 9%; Crohn, 20%; and Shiff, 26.4%. In some of the above series hemorrhages were not reported as obscure until intensive study and exploration failed to reveal the source. Our personal series of gastrointestinal hemorrhage reveal 11% to be of obscure origin based on our definition.

*The Preliminary Survey.*—A good review of the past and present history of the patient provides much information. An orderly question survey of the gastrointestinal tract is of value. Hematemesis almost invariably places the source

above the ligament of Treitz and above the pylorus if bright red. Massive hemorrhage and a history of alcoholism suggests esophageal varices as the source. Less severe hematemesis and melena associated with loss of weight and appetite suggests carcinoma of the stomach. A history of known duodenal ulcer with or without hemorrhage may be obtained. If a suggestive history is associated with vomiting of red to coffee ground blood, and with melena a diagnosis of bleeding duodenal ulcer seems assured. A more massive hematemesis suggests a gastric or esophageal lesion rather than duodenal. A history of recent mental or physical strain or respiratory infection followed by hemorrhage strongly suggests a bleeding peptic ulcer.

Melena suggests bleeding from the upper small bowel, generally a duodenal ulcer. Reddish brown blood, however, may be seen rectally if bleeding from the upper small bowel is severe.

The physical examination will often give quick leads to the diagnosis. The degree of pallor, thirst, sweating, vomiting and hypotension give a quick index to the extent of the hemorrhage. A palpable liver and ascites suggests cirrhosis, and evident weight loss suggests carcinoma of the stomach. An apparently satisfactory general physical condition suggests a duodenal ulcer.

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Abdominal and rectal examination may demonstrate a tumor mass.

Laboratory studies of this preliminary survey include urine, routine blood count, hematocrit and prothrombin time. Blood dyscrasias may be suggested.

The above study of the patient takes only a few minutes, yet the presumptive diagnosis can be established in 75 to 90% of the cases of hemorrhage. Case studies offer confirmation of this. Costello<sup>3</sup> in his study of gastrointestinal hemorrhage reported 57% duodenal and 11% gastric ulcer (or 68% peptic ulcer), 8% esophageal varices and 4% gastritis. Halligan et al<sup>4</sup> reported approximately 60% duodenal and 12% gastric ulcer (or 72% peptic ulcer) esophageal lesion 10 to 20% and malignancy 4%. Jankelson and Segal<sup>5</sup> estimated 80 to 90% of all upper gastrointestinal hemorrhages to arise from peptic ulceration. In our series of 226 consecutive cases of gastrointestinal hemorrhage we found 56% duodenal and 12% gastric ulcer (68% peptic), 13% carcinoma of the stomach and 8% carcinoma of the colon. This leaves 11% as representing the more unusual type for which further investigation is necessary.

*Further Investigation.*—How further investigation is carried out is dependent upon the degree of hemorrhage. Obviously if the hemorrhage is massive, supportive and replacement treatment has been started at once and is continued as necessary. If the bleeding is less severe a more deliberate approach is possible.

The keystone of further investigation is the x-ray examination. The x-ray examination along with the preliminary survey will reveal the lesion in approximately 90% of the cases. There exists some differences as to when x-ray studies should be carried out. Some writers<sup>6</sup> urge immediate x-ray and esophagogastros-copy and others prefer to await cessation of hemorrhage. Our attitude has been to support the patient until bleeding has been arrested for seven to ten days. We feel that x-ray examination during active bleeding increases the burden of control. The early insecure clot that blocks the bleeding vessel may be dislodged by manipulation during early x-ray examination. Furthermore, edema about an ulcer or clot within the crater may prevent visualization of the ulcer by early x-ray examination.

The same attitude pertains to esophagogastros-copy with certain reservations relative to persistent massive bleeding. If the preliminary survey suggests bleeding from esophageal varices associated with cirrhosis we order at once a bromsulfaline liver function test. If we find 25 to 50% retention after 15 minutes we may assume our preliminary suggestion is correct. If bleeding has subsided we delay several days for further examination. If vomiting of blood is severe and persistent we may advise immediate esophagogastros-copy. If bleeding varices are found tamponage by the two bag method may be instituted as a life saving method. Treatment must not be compromised by delay in diagnosis. Based on our preliminary survey, treatment is instituted and carried out as is indicated.

This first x-ray examination may not reveal a lesion. The patient may have returned to well being and may never bleed again. We must, however, exhaust all means to uncover the cause of these obscure gastrointestinal hemorrhages.

Repeat x-ray studies using special techniques is the next step. Careful search of the stomach must be made for small tumors, polyps, hypertrophic or atrophic gastritis, para-esophageal hernia and other lesions. Since 60% of gastrointestinal hemorrhage is from duodenal ulcer the duodenum must be carefully studied, using all the various positional, manipulative and barium swallow techniques at the command of the roentgenologist. Superficial ulcers particularly of the posterior duodenal wall, filling defects of small tumors, irritability of duodenitis and other lesions may be noted. Careful serial studies must then be carried out on the small bowel for tumor, diverticulum, granuloma, and other lesions. If red or reddish brown blood is noted rectally the same careful study of the colon must be made following careful proctoscopy.

Esophagogastros-copy is indicated if negative reports are given by the roentengologist. Gastritis, superficial ulceration, varices of the esophagus or cardiac stomach may be noted among other lesions.

By this time we have conducted a preliminary survey by history, physical and laboratory examinations, a preliminary x-ray examination after a few days and later a careful deliberate re-examination by x-ray, esophagogastros-copy and proctoscopy. If the source of the hemorrhage

is not now disclosed, and particularly if this is the patient's first hemorrhage, we are inclined to place the patient on an ambulatory ulcer type diet for a few weeks and await further activity. Several of these patients will not further bleed and we do not pursue the study further.

If a second episode of bleeding occurs the same studies are repeated. If no negative reports are obtained exploration is considered and probably advised.

We have assumed that the bleeding has subsided. If the hemorrhage does not promptly subside, is massive and no help is obtained from the preliminary survey, exploration is justified. It should not be delayed too long. Even if initially severe, the majority of hemorrhages will however subside and permit of more definitive study. In this regard we have not been impressed with the "change in prognosis after 45" rule. We have not had much success allowing various diets during bleeding. Cessation of bleeding often will promptly follow the omitting of all oral feedings, water and medication. The maintenance of blood volume is of primary importance. Prolonged hypotension leads to severe anoxemia with resultant serious changes in vital organs including the brain and medullary centers. These changes may be irreversible. Kidney failure even to oliguria may follow. The adrenals will be injured by prolonged anoxemia.

The exploratory examination at operation must be thorough. An adequate incision is essential. The esophageal hiatus, stomach, duodenum, the small and then the large bowel are carefully examined by palpation and visualization. Careful attention must be given to the biliary tract, pancreas and vascular mesentery of the bowel. The stomach or duodenum must be opened if blood is seen therein and opened adequately to thoroughly visualize the entire lining if this be necessary. The same attack pertains to the rest of the bowel. The biliary tract and the pancreas must be visualized adequately to determine if blood is present within the ducts or organs. Few cases of active bleeding will escape this search.

If exploration is performed after all bleeding has stopped, the same principles of detailed search must be observed. The stomach or bowel must be opened and adequately explored if

indicated. Subtotal gastric resection has been advised by several authors<sup>7,8</sup> when exploration during an interval bleeding phase fails to reveal the lesion. Case reports of unsuspected superficial erosions found within the resected specimens are recorded. Successful control of recurrent hemorrhage has been reported even though the stomach appeared normal at exploration. However, many of these so-called blind erosion and similar lesions will be revealed by inspection through an adequate generous gastrotomy. Formidable gastrectomy must not be entered into lightly in the absence of an evident lesion.

*Examples of Obscure Gastrointestinal Hemorrhage.*—If we can have an organized approach to the problems of obscure gastrointestinal bleeding and an awareness of possible lesions, we will be able to approach the management and treatment of such cases more successfully. Table 1 is a compilation of some of the more commonly reported cases<sup>9</sup> from the literature. I have noted

TABLE 1

## OBSCURE GASTROINTESTINAL HEMORRHAGE

### EXAMPLES FROM LITERATURE

#### Gastric

- Leiomyoma
- Sarcoma
- Fundus Varices
- Gastritis
- Diaphragmatic Hernia

#### Intestinal

- Meckel's Diverticulum
- Inflammatory Granulomas
- Specific Ulcerations
- Polyps
- Diverticulosis
- Rendu-Osler Disease

#### Biliary Tract

- Erosion of Cystic Artery
- Trauma to Liver
- Carcinoma

#### Others

- Carcinoma of Pancreas
- Aneurysm of Aorta
- Leukemia
- Purpura
- Hypertension
- Arteriosclerosis
- Psychogenic

TABLE 2  
OBSCURE GASTROINTESTINAL HEMOR-  
RHAGE  
EXAMPLES FROM WHITTAKER-HART  
SERIES

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Fundic Stomach Erosions
Diaphragmatic Hernia
Localized Duodenitis
Carcinoma of Duodenum
Carcinoma of Jejunum
Carcinoma of Pancreas
Mesenteric Thrombosis
Telangiectasis of Intestine

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with interest that varices may occur about the cardiac stomach as well as in the esophagus. These, of course, may be approached more directly. Rendu-Osler disease is an hereditary hemorrhagic telangiectasis involving mucous membrane including the gastrointestinal tract. Table 2 is a compilation of some of the more interesting cases from our own series. In addition to cardiac and fundic varices minute erosions, even involving submucosal arteries, may defy detection unless the stomach is opened widely enough to fully visualize the lining. The x-ray will usually suggest possible ulcers within the herniated stomach.

A 54-year old man had repeated small hemorrhages with repeated x-ray studies showing a diaphragmatic hernia but no intrinsic gastric lesion. At operation we could find only edema of the fundic stomach. Following repair of his diaphragmatic hernia no further bleeding occurred

The localized duodenitis was found at exploration after a series of hemorrhages in a girl of 23 over a 4-year period. Repeated x-ray studies were normal. The duodenum was opened. An area 1.5 cms. in diameter was granular and bled on contact. It was excised. The pathologist reported duodenitis — no ulcer. There has been no further bleeding in 9 years.

A man aged 39 had repeated tarry stools and x-ray studies suggested an anomaly of the transverse duodenum. Exploration revealed a polypoid carcinoma of the transverse duodenum.

Carcinoma of the pancreas must be remembered. A man, age 72, in obvious decline had normal gastrointestinal x-ray studies. He was

later admitted to the hospital in shock from hemorrhage with vomiting of coffee ground blood and with melena. The autopsy later revealed a carcinoma of the pancreas with invasion of the duodenum and erosion of the pancreatico-duodenal artery.

Mesenteric vascular occlusion is usually suggested by related disease but may occur without evident cause and without suggestive history. We had one such case in a laboring man, age 28.

The case of telangiectasis of the small bowel was associated with large mesenteric and subserosal veins. It was not Rendu-Osler disease. It occurred in a young farmer, age 23. Bleeding episodes always followed heavy work or other strain. Repeated x-ray and laboratory studies were negative. Biopsy of the mucous membrane at exploration revealed only hyperplastic mucous membrane. The lesions may have represented multiple small arteriovenous aneurysms.

#### SUMMARY

1. The great majority of cases of gastrointestinal hemorrhage are diagnosed as to source by routine preliminary history, physical and laboratory examinations and confirmed x-ray.
2. There remains a significant group of cases with obscure etiology.
3. Repeated and broadened studies made after bleeding has subsided will reveal the source in many of the obscure cases.
4. Exploration is indicated if recurrent episodes of bleeding occur, or if bleeding dose not subside.
5. An orderly study of the patient and a knowledge of possible sources of hemorrhage in obscure cases will contribute to the successful management of such cases. Representative examples of obscure bleeding are listed to this end.

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# Total Rehabilitation of the Cardiac Patient

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The greatest and most valuable of all of our resources is manpower, the ability and willingness to work. It is estimated that ten million persons with cardiovascular-renal disease in the United States lose one hundred and fifty-two million workdays a year. Total rehabilitation, including selective job placement and adequate medical follow-up, means the return of these individuals to gainful employment with less workdays lost and productive lives with a definite measure of happiness and satisfaction as useful citizens. Physical Medicine and Rehabilitation does not supersede, or take the place of the medical program for the patient, however, it is part of the total medical management and will be discussed in this paper.

People with heart disease, frequently, and to a greater or lesser degree, have anxiety, fear, apprehension and other psychological, emotional

and social conflicts. There is a certain amount of restlessness and psychological tension. His future appears dark and insecure; a feeling of helplessness overcomes him. This situation can be overwhelming to any person, especially when he is first told that he has a heart condition or when he has his first so-called "heart attack". Frequently, this person is one who, prior to his attack, had been highly active and considered a healthy person. It must also be remembered that the family of the patient is often faced with many emotional and social problems, especially when the disease is of long duration and more so when the patient is the sole breadwinner of the family.

The scope and immensity of the rehabilitation problems quickly rule out total rehabilitation as being a one-man job. A sick human being is entrusted in our care. Therefore, teamwork by the internist, physiatrist (specialist in Physical Medicine and Rehabilitation), and other specialists, including the various rehabilitation therapists (physical therapist, occupational therapist, corrective therapist, manual arts therapist, educational therapist, and the vocational counselor), nurse, dietitian, social worker, and others, is our responsibility and is significantly vital in order to meet the total needs of the patient. For special problems, it may be helpful to secure the assistance of the psychiatrist and the psychologist. In many instances social service is also of value in the overall rehabilitation planning. Full use must be made of the patient's hospitalization period.

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Peace of mind for the cardiac patient can be aided by his getting back to a purposeful occupation, such as, back to school, self-employed or by being employed by others. However, a sheltered workshop, an institutional work program or home-bound work should be considered for some patients as a means of filling the gap between the time of discharge from the hospital or clinic and more independent employment. With selective job placement he effectively and efficiently performs a job within his capabilities without any undue risk to himself or his fellow workers. This further aids in overcoming emotional and psychological difficulties since many cardiac patients are ready, willing and able to perform useful work.

All concerned with rehabilitation, including the employers in business and industry must be aware of the capabilities and potentialities of the cardiac patient and of their role towards the patient's own security and the economic status of the community. All medical, social and community agencies must also take part in this vast program of back-to-work and their resources effectively used. Planning the future for one with heart disease must start while he is still in the hospital so that post-hospital adjustment and suitable employment may be more effective. Participation in rehabilitation must be started as soon as medically feasible. There must be a realistic awareness of what can be accomplished as well as the limitations to rehabilitation. A thorough evaluation is made of each individual under consideration in order to meet his specific needs. It would be folly to envisage every cardiac patient returning to his former work capabilities. There is a certain significant percentage who will be limited not only as to the type of work they can do but also to the amount.

Just as there is selective job placement after discharge from the hospital, there should also be selective treatment activity during hospitalization to meet the specific needs of the patient. Placement follow-up is necessary, as the patient's condition, as well as the job requirements, may change. The patient's total needs are best met without any interruption in the total program by carefully coordinating and integrating the hospital program with the post-hospital plans. One must avoid job placement where the patient may be in a state of "nervous tension", "anxiety"

or even "frustration" because of the particular type of work he is doing, as these factors may predispose to another "heart attack".

In the process of work classification it is necessary to be specific as to the physical and mental job requirements and to match this with the physical and mental work capacity of the patient. It is certainly insufficient to say "light work", "sedentary job" etc. There should be an exploratory approach to the job solution which can be initiated during the patient's hospital stay and carried on further in a rehabilitation clinic or institution.

Careful detailed consideration of all factors in selective job placement of the patient must be evaluated, such as:

- a. Can he return to his former job or similar employment?
- b. Can he work full-time or must his activity be restricted to part-time employment?
- c. Can he safely travel to and from his place of employment?
- d. Will the job present factors that will give him "nervous tension", anxiety and fear and result in conflicts with his family?
- e. Will there be proper understanding between him and his employer to dispel any fears that may lead to frustration?

#### OBJECTIVES OF TOTAL REHABILITATION

A total program participated in by all members of the rehabilitation team to fill the needs of the cardiac patient will be discussed. The amount of activity for cardiac patients must be based upon many factors other than the amount of cardiac impairment and its operating capacity, such as emotional conditions and cardiac anxiety, which will affect the patient's ability to engage in useful work.

It must be remembered that modifications of any program are made by the physician, depending upon the patient's total clinical picture, and therefore, any outlined program should only serve as an activity guide.

In a jointly integrated program by the Physical Medicine and Rehabilitation Service and the Medical Service (cardiac section) at the Veterans Administration Hospital, Hines, Illinois, Newman, Andrews, Koblisch, and Baker,<sup>1</sup> in discuss-

1. Newman, L. B.; Andrews, M. F.; Koblisch, M. O.; and Baker, L. A.: Physical Medicine and Rehabilitation in Acute Myocardial Infarction, A.M.A. Archives of Internal Medicine, Vol. 89, pp. 552-561, (April) 1952.

ing the immediate rehabilitation objectives of 527 patients with acute myocardial infarction, listed the following points which are also applicable when dealing with other types of cardiac conditions:

1. To teach the patient both psychological and physical rest.
2. To instill a proper mental attitude in the patient toward his illness and to prevent the development of anxiety neurosis.
3. To restore muscle tone and strength in order that the patient may be ready for physical activity.
4. To aid in prevention of peripheral circulatory stasis, which is conducive to phlebotrombosis.
5. To help the patient understand his physical limitation and how to control his activities during convalescence and after discharge.

The physician's task and responsibility is to carefully prescribe controlled activities, including ambulation which is adjusted depending upon the patient's reaction to the activities, and the rate and amount of progress. All personnel should be cognizant of any untoward symptoms or complications, such as pain, dyspnea, palpitation, unusual changes in the pulse or blood pressure, extreme anxiety, etc., so that changes can be immediately made in the activity program.

Under careful supervision, the patient is instructed in specific exercises for the entire body starting with movements of the hands and feet. Additional exercises are gradually added as well as the number of times each exercise is performed. Relaxation, diaphragmatic breathing exercises and posture training are also included. All of these activities lead to progressive walking over measured distances and also gradually increasing amounts of stair-climbing as shown in Figure 1. Here the patient is descending stairs under supervision of the therapist who is also checking posture and gait. A conveniently placed chair is needed so the patient can rest. Not only is this an activity of daily living but it also increases work capacity.

The bedside commode should be used when prescribed, as there is less stress and strain upon the patient during defecation than when a bedpan is used. Benton, Brown, and Rusk<sup>2</sup> have

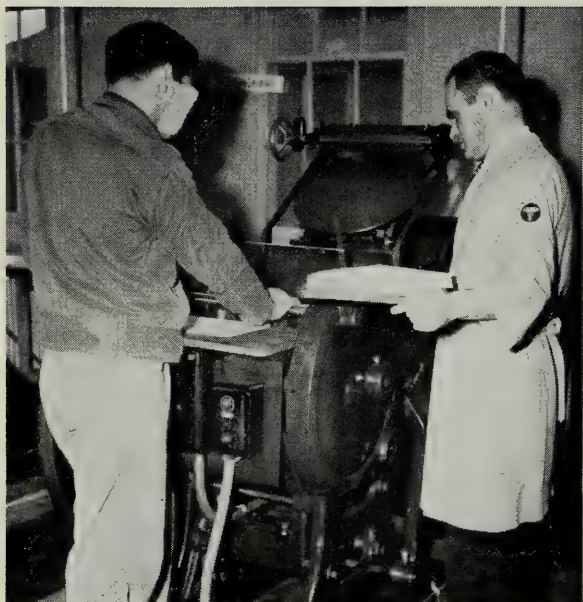


**Figure 1: Cardiac patient walking up and down stairs under careful supervision of the therapist. Note the chair that is placed in a convenient position so that the patient can rest. Good posture with proper gait is emphasized.**

compared the energy expended when using a bedpan and a bedside commode. They concluded that from both a postural and energy-conserving standpoint, the strain necessary for defecation is lessened by the use of a commode and, further, that energy expenditures in terms of oxygen consumption was 50.7 per cent higher on the bedpan than on the commode. It has further been observed clinically that at times, and in many instances, it is less trying and more relaxing to the patient to sit in a comfortable armchair at the bedside than attempt to sit over the edge of the bed when eating, reading or participating in certain of the rehabilitation activities.

A not infrequent complication that is seen in cardiac patients, especially those with myocardial infarction, is the shoulder-hand syndrome. This condition may develop in the left shoulder, right shoulder, and at times, both shoulders, and can involve the arm and hand resulting in pain and stiffness with limitation in motion, especially in abduction and external rotation of the shoulder. It appears to be a periarthrititis, and if untreated, can result in marked disability and impaired function of the shoulder and arm. Stiffness and flexion deformity of the fingers with atrophy of the intrinsic muscles of the hands, will result in varying degree. It is felt that immobility of the shoulder during bedrest, together

2. Benton, J. G.; Brown H.; and Rusk, H. A.: Energy Expended by Patients on the Bedpan and Bedside Commode, J. A. M. A. Vol. 144, pp. 1443-1447, (December) 1950.



**Figure 2: Cardiac patient operating a printing press. This activity improves coordination, develops skill and increases work capacity. It further aids in exploring for a vocational goal.**

with limited activity, are contributing factors to this shoulder-hand syndrome. If a proper activity program is initiated early, this condition can be prevented. Therefore, slow careful movements of the shoulders and upper extremities should be instituted at the earliest possible moment even though these movements need only be done initially once or twice a day. Movements should be carried through full joint range and include clasping the hands behind the head with the elbows completely abducted. Mild heat may be used to relieve pain and spasm during exercise or when shortened muscles need to be gradually stretched.

The cardiac patient may participate in jewelry making or typing while still confined to bed although this can be continued later as a possible vocational objective. This type of activity, which is gradually increased in amount, provides active exercise for the upper extremities and shoulders, improves dexterity and increases the patient's work capacity.

Figure 2 shows a cardiac patient operating a printing press for this activity was selected as his vocational goal. Further, it improves coordination, develops skill and increases work capacity.

Figure 3 shows a cardiac patient operating a screw-cutting metal lathe. This is done under the close supervision of the therapist. Note that

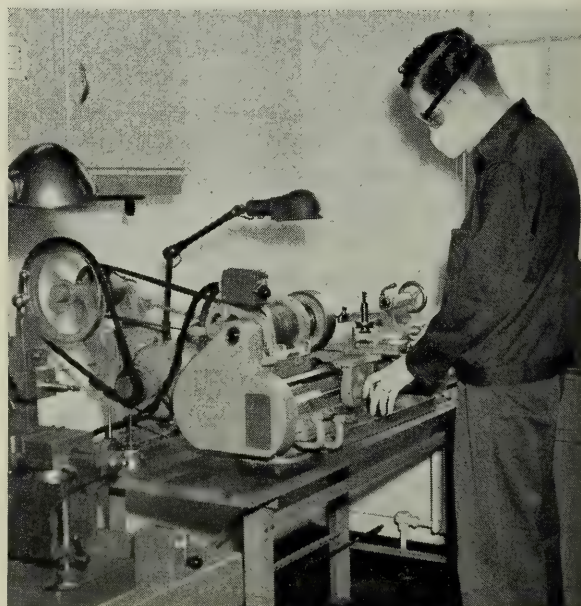
the patient is wearing safety goggles. This activity not only serves for vocational objective exploration, but also improves coordination, develops skill and increases work capacity.

These and other activities also aid in increasing the patient's physical and mental capacity, overcome monotony and boredom, and when integrated and coordinated with vocational counseling, lead to productive and useful goals for the cardiac patient.

When participating in any activity, the pulse rate, volume, and rhythm as well as the type and rate of respiration is noted and recorded by the therapist prior to, at the end of, and after a three-minute rest period following the prescribed activity. If there is an increase of more than 10 in the pulse rate after the rest period or if the respirations are unusual, the treatment is discontinued and these facts are reported to the physician for his consideration. As a matter of fact, all of the therapists are carefully instructed that whenever pain or any other unusual signs or symptoms develop, to promptly discontinue the treatment activity and report the matter to the physician.

#### SUMMARY

1. Physical Medicine and Rehabilitation is part of the total medical care of the cardiac patient and does not replace or substitute for the medical management.



**Figure 3: Cardiac patient operating a metal lathe which improves coordination, increases work capacity, develops skill and also serves as a vocational objective exploration.**

2. The importance and benefits of a medically directed, thoroughly integrated and coordinated rehabilitation program, balanced for activity and rest, to fill the specific needs of the cardiac patient, has been stressed. The objectives and procedures have been presented.

3. The importance of teamwork of all those concerned in rehabilitation and the proper awareness and understanding of the rehabilitation potentials is essential to achieve satisfactory results. The overall medical picture governs the rate and amount of rehabilitation.

4. Complete evaluation of the patient must be made to best determine medical feasibility for the particular type and amount of work that is being considered. Employment without undue physical strain or mental and emotional stress is of prime importance.

5. Early diagnosis, properly prescribed and instituted medical care and rehabilitation, periodic follow-ups as well as a thorough educational program for the patient, family, friends and em-

ployers, will brighten the future for those individuals with cardiac conditions.

6. With an organized rehabilitation program for the cardiac patient both the physician and the patient, prior to and at the time of discharge from the hospital, will have a good appreciation of the patient's work capacity, his post-hospital plans, and vocational goal.

7. Inasmuch as heart disease is the leading cause of death in the United States, it is significantly urgent that research, both basic and clinical, and education be continued for it will add happiness and satisfaction, as well as years, to those with this disease. Then life will be longer, wider and deeper.

The authors are greatly indebted to the personnel on the Cardiac Section, and the Physical Medicine and Rehabilitation Service at the Veterans Administration Hospital, Hines, Illinois, for their cooperation and splendid accomplishments in the program and to the Medical Illustration Laboratory for their excellent photographs.

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## ASPHYXIATED BABIES

The prime consideration in handling asphyxiated babies are gentleness, maintenance of body temperature, and oxygenation of their blood and tissues. If these three aims are effectively and quickly carried out, the babies can be maintained for an indefinite period of time with no harm done and spontaneous voluntary respiration almost invariably begins. If, however, the baby is mauled and traumatized, the body temperature drops, anoxia deepens, and the baby rapidly progresses into an irreversible state of shock and asphyxia. The old methods of spanking, swinging, manual artificial resuscitation (squeezing the chest), and dousing in or with cold water should be considered entirely obsolete. The first procedure necessary is to clear the baby's airway of blood, amniotic fluid, or mucus that might be aspirated into the trachea and bronchi with

the first respiratory effort. How this should be accomplished has been a matter of debate for many years. Some have advocated intubation of the trachea by direct laryngoscopic methods in all of these severely asphyxiated infants. This is a highly technical procedure and should be done only by those well trained in its application. Flagg, who is a prominent exponent of this method, has recently been quoted as saying that he believes the merit of the procedure is not the aspiration of obstructing material but the direct introduction of oxygen into the trachea. I do not believe that direct intubation is necessary. I believe that it is sufficient to strip the mucus out of the trachea with the external finger and aspirate it from the mouth, nose, and nasopharynx with a soft rubber catheter. *J. E. Morgan, M.D., and Carmen T. Reyes, M.D., Resuscitation of the Newborn. Ohio M. J. April 1954.*

# Approaches to the Control of Tuberculosis

**Meyer R. Lichtenstein, M.D., Clinical Associate Professor of Medicine,  
Sol R. Rosenthal, M.D., Associate Professor of Preventive Medicine and  
Karl H. Pfuetze, M.D., Clinical Professor of Medicine**

**SEMINAR  
of the  
DEPARTMENT OF MEDICINE  
of the  
UNIVERSITY OF ILLINOIS**

**Edited by:**

**Dr. Max Samter  
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*Dr. Samter:* Control of tuberculosis in recent years, has become a psychological as well as a medical problem. The public, and this includes a fair number of practicing physicians, has been led to believe that the disease has practically disappeared while the experts emphasize that in spite of our spectacular therapeutic armamentarium, it is far from being conquered.

*Dr. Rosenthal:* Although the mortality from tuberculosis has fallen sharply in the last twenty years, the case rate has remained high and even increased in some of the large cities. Any method which will reduce the yearly case rate should be strongly encouraged.

I have shown over a twenty year period that BCG is safe and that it can reduce the incidence of tuberculosis from 54 to 100% depending primarily upon the degree of exposure. Secondary factors are housing, nutrition, and education. The lowest morbidity and mortality was obtained when BCG vaccination supplemented a complete tuberculosis control program. BCG vaccination benefitted infants, children, and adults most where some type of a tuberculosis control program was in effect.

In those individuals (children and adults) having casual contact with tuberculosis, the factor of good housing plus BCG vaccination reduced the morbidity 100% as compared to con-

trols in three distinct groups of individuals — medical students, children from two orphanages (white) and in a housing project (colored). BCG vaccination in newborns and children who live in substandard housing reduced the morbidity 75% as compared with controls. Where there was known contact with tuberculosis BCG vaccination in individuals who were well housed, reduced the morbidity 68% (newborns and children) and 54% in student nurses.

Recently, we have developed a freeze-dried vaccine which can be stored for periods up to three years. Thus, it is now possible to completely standardize the vaccine for sterility, viability, and potency before distribution. We have also developed a new method of vaccination by the multiple puncture method using a stainless steel disc with thirty-six projections. This method is simple in application and produces no complications and leaves no scars.

*Dr. Lichtenstein:* The ambulatory therapy of patients with tuberculosis has been developed as a necessity. To give you a little background as to the reasons involved in the development of this program, let me state that in January, 1953, there was a waiting list of six hundred and two patients for M. T. S., with only fourteen hundred beds available. Some patients had been waiting for two and one-half years, and one hundred and sixty new applications were received every month.

The first part of the plan of action was the post-Sanitarium chemotherapy program. This, in general, consisted of the early discharge from the Sanitarium of patients with negative sputum and closed cavity, but with x-ray evidence of active disease. These patients then lived at home and received their chemotherapy at our out-patient clinics. Streptomycin, PAS, and isoniazid were used routinely. During the first year of the program, over five hundred extra patients were discharged thus allowing the same number of extra admissions from the waiting list. By this pro-

gram, we were able to increase the admission rate from approximately ninety-five to one hundred and forty-five patients per month.

The other part of the program was the pre-Sanitarium chemotherapy program. In general, those patients who would have to wait over one month for admission were started on chemotherapy promptly and continued until a bed became available. Four hundred and seventy-two patients received treatment in this manner during the first year.

With this regimen, we have treated ten hundred and thirty-six patients. At the present time, we have eight hundred patients under therapy. We do not treat those patients who fail to cooperate.

It has been our experience that the post-Sanitarium program has been the most successful. The rate of relapses of this carefully selected group is under two percent. The pre-Sanitarium group, however, has been a dismal failure. We find that the therapy improves the patients symptomatically and they subsequently refuse to come into the hospital, and frequently stop treatment when surgery is advised. The hospitalized patient, on the other hand, sees the excellent results of surgical treatment and is glad to accept it.

Operation of the program reduced the waiting list to one hundred and thirty after one year, with no patient waiting more than four months.

*Dr. Pfuetze:* We cannot forget that tuberculosis is a chronic disease that tends to recur. The mortality has declined steadily over the past fifty years. From 1945 to 1950 there was a fifty percent drop in mortality. We may take some comfort in the fact that Chicago is not the number one city as far as tuberculosis mortality is concerned. I would like to comment on some observations as far as racial differences are concerned. We find, in general, the Negroes are more susceptible and develop more complications than white individuals. We must point out that the death rate from tuberculosis was decreasing before the onset of chemotherapy, however the decrease has been much more rapid since the advent of chemotherapy.

At this point, I wish to discuss the groups of patients who are frequently treated at home by a family physician. I want to emphasize that this program is feasible in some cases, but requires (1) a cooperative patient, and (2) a physician

who knows tuberculosis to treat it intelligently. At the present time I know of no consecutive series of patients who have been treated at home that has ever been reported. We feel that the responsibility of the private physician is to be conscious of tuberculosis at all times and be alert to discover it among his patients. The important aspects of any good case finding program are (1) a high index of suspicion on the part of the physician, (2) mass community x-ray surveys, (3) x-ray surveys in industry because in these we have a "captive" group, and (4) routine hospital admissions chest x-rays.

*Dr. Mark Lepper:* Where is the next logical expansion of BCG?

*Dr. Rosenthal:* We follow the recommendations of the American Trudeau Society, who recommended BCG vaccination for medical students, nurses, and laboratory personnel, individuals unavoidably exposed to tuberculosis in the home, patients and employees in mental hospitals, prisons, etc., children and certain adults living in communities where the tuberculosis mortality is unusually high.

*Dr. Lichtenstein:* I would want to consider that last statement. I have my doubts as to whether it would be feasible. We have to remember that it is difficult to follow patients in the high incidence areas. For example in the Provident Clinic district, we have a twenty-three percent turnover in patients in one year. You see it is manifestly impossible to follow such patients over a period of years.

*Dr. Rosenthal:* It is necessary to reduce the degree of contact to open cases of tuberculosis. No vaccine can withstand unlimited exposure to the corresponding disease. For this reason, it is necessary to isolate the open cases in sanatoria and vaccinate the negative reactors from such households making sure that these individuals are not in their pre-allergic stage. In high incidence areas, the children of known cases of tuberculosis as well as those who are not exposed to tuberculosis should be vaccinated. The testing and vaccinating of these individuals could be best accomplished by working through the schools.

*Dr. Pfuetze:* I would gladly give up the Mantoux test as a diagnostic test even if the efficacy of BCG is as little as twenty percent decrease in the incidence of tuberculosis.

*Dr. Norman Roberg:* I feel that we must point out at this time that the Mantoux Test is not a diagnostic test for tuberculosis, but is only an index of exposure to tubercle bacillus.

*Dr. Lichtenstein:* I wish to state at this time that I have no bias, but I believe that there is valid reason to doubt the efficacy of BCG. There is much data that suggests that the immunity granted is slight and is only of short duration. In many places the mortality has been reduced even where no tuberculosis control work has been done. In areas where an extensive tuberculosis control program has been initiated there has been a greater decrease in mortality and morbidity than in areas such as Denmark where there has been an extensive vaccination program. However, I feel that it does offer some protection for a limited period of time. We still need conclusive experiments to prove this point. To summarize, I doubt that it is necessary to use vaccination on a country wide scale.

*Dr. Rosenthal:* To make a comparison between countries, one using BCG and the other not using BCG is hazardous. A frequent comparison is made between Iceland and Denmark. In Iceland, where no BCG is used, there has been reduction of the mortality of some seventy percent from tuberculosis between the years of 1945 and 1950. In Denmark where BCG is used, the reduction during the same period was only fifty-eight percent. However, what is not taken into consideration is that there are three people per square mile in Iceland and two hundred and twenty-eight per square mile in Denmark. This factor alone is enough to invalidate any comparisons between the two countries. It may be of interest to note that the mortality in Denmark in 1953 was ten per hundred thousand, the lowest in the entire world.

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## ARE GERMS BECOMING RESISTANT?

There exists a popular impression, shared to some extent even by the medical profession, that the antibiotics are losing their punch due to a rapid development of resistant micro-organisms. Any such dogmatic assertion regarding penicillin certainly requires qualification in the light of observed facts. On examination, the case for increased bacterial sensitivity to penicillin is based chiefly upon reports describing insensitive strains of staphylococci. Romansky and Kelser, as of 1952, stated that "to date the pneumococci and group A hemolytic streptococci, the organisms

most commonly found in diseases of the respiratory system, have shown no evidence of development of resistance to the available agents." In the same year, Garrod in Britain, told the Royal Society of Medicine, that while most bacteria can be habituated to penicillin in the laboratory, this ordinarily does not happen in the body, except in the case of staphylococcus. And more recently, Perrin Long could find "no clear evidence that Beta hemolytic streptococcal, pneumococcal, meningococcal, or treponemal infections have become appreciably resistant to the antibacterial effects" of penicillin. *W. D. Paul, M.D., Penicillin and its Problems. South Dakota J. Med. & Pharm. April 1954.*

# Polypoid Disease of the Colon and Rectum

Caesar Portes, M.D., and James H. Cross, M.D.  
Chicago

It is an accepted fact that there is a significant relationship between polypoid disease of the large intestine and carcinoma. Intestinal adenomas become carcinomas in significant numbers and precede carcinomas in age grouping. The sigmoid and rectum contain the largest number of both adenoma and carcinoma and frequently they coexist. These facts have been emphasized by Bacon.<sup>1</sup> Helwig<sup>2</sup> in a study of 1460 consecutive autopsies showed adenomas are neoplasms that often become carcinoma. Although carcinoma may arise in situ, rather than as an adenoma, it will still commonly project into the lumen as a polypoid mass. Conceivably carcinoma may also arise from an ulceration but if this ever happens it is indeed rare. The treatment of carcinoma of the colon and rectum with radical procedures still gives us a considerable mortality. In contrast, many series of malignant polyps are reported with little or no mortality rate. Our continued interest in the early diagnosis and adequate treatment of polypoid disease is then quite justifiable.

Polypoid disease of the colon and rectum usually is adenomatous. These adenomas may be

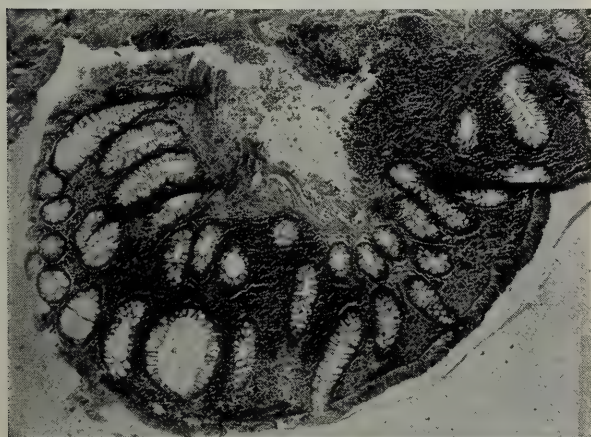


Figure 1. Benign sessile polyp.

sessile (Figure 1) or pedunculated (Figure 2). They vary from minute mucosal excrescences to the diffuse polyposis of either the inflammatory (Figure 3) or familial (Figure 4) type. A villous or papillomatous adenoma with its mul-



Figure 2. Benign pedunculated polyp.

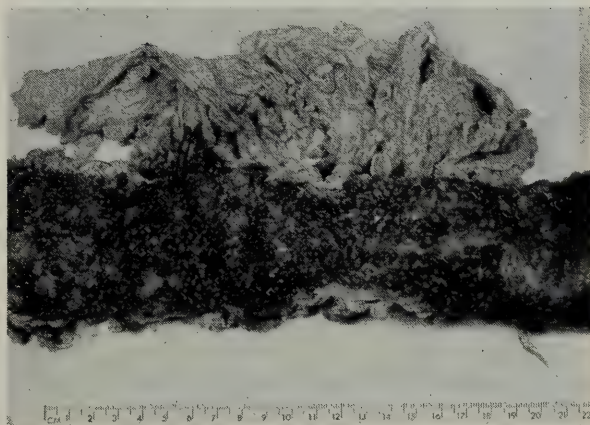


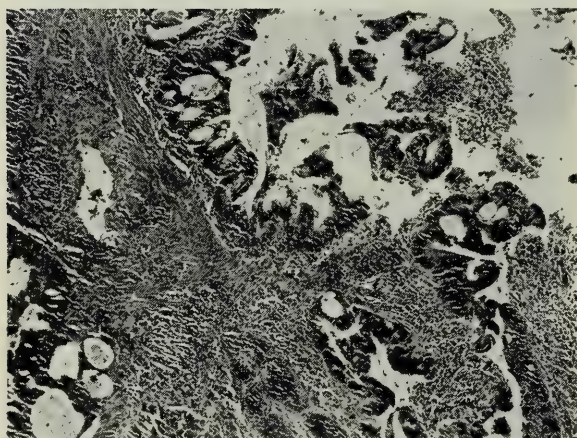
Figure 3. Diffuse polyposis (inflammatory type).

tipile villous projections is especially significant because of its proclivity to recur. Warren<sup>3</sup> states that anaplasia, irregularity of architecture, and invasion are the criteria for malignancy (Figure 5) and that at least two must be present.

Portes<sup>4</sup> has reported a polyp incidence of 8% in 5000 cases of patients given routine procto-



**Figure 4. Diffuse polyposis (hereditary type).**



**Figure 5. Malignant polyp showing anaplasia, irregularity of architecture, and invasiveness.**

scopic examination. Swinton<sup>5</sup> in a study of 1843 consecutive autopsies found 7% had polyps of the large intestine. More than one polyp is found in about half of the patients with polypoid disease. Polypoid disease usually presents about a 3 to 2 ratio of men to women. Diffuse polyposis is not infrequent.

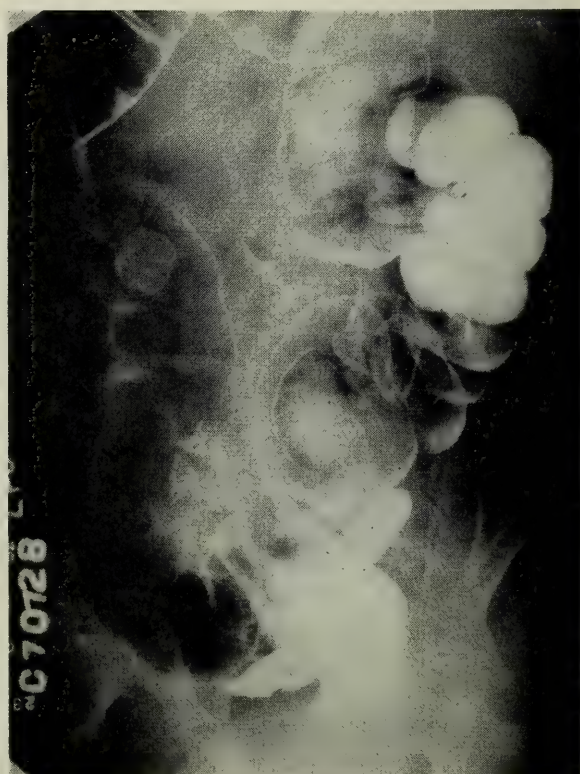
The symptoms of polypoid disease are usually minimal. If pedunculated there may be irritation and a history of bleeding. An occasional intermittent attack of colic may be associated with

polypoid disease. A change in the functional activity of the bowel may be noted. A considerable number are asymptomatic. The disseminated lesions of course are associated with the history of their primary disease.

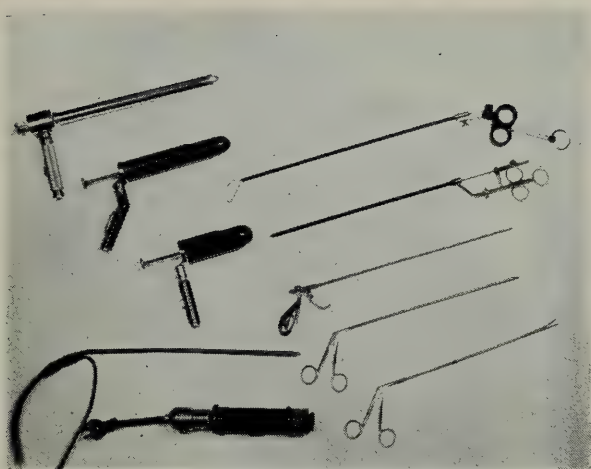
A willingness to examine the rectum and colon is mandatory. Digital examination will occasionally reveal the larger polyps. The proctoscopic and x-ray examination are of course the primary diagnostic aids. Needless to say proctoscopy should be performed on any patient with rectal bleeding or other altered intestinal function of any duration.

Proctoscopic examination to the extent of 25 cms. cannot be replaced by x-ray and rarely is x-ray of this area supplementary. There is no substitute for direct vision of the rectum using the proctoscope. Proctoscopic examination should be performed at the slightest indication.

Barium enema should be added to proctoscopic examination if there is any evidence of polypoid disease and of course if there is bleeding or other indication. The air contrast enema has greatly improved our early diagnosis of polypoid disease. Weber<sup>6</sup> states lesions of 1 cm. or less can be recognized by x-ray. The value of the air contrast enema should be emphasized. Using a thin



**Figure 6. Polyp visualized by air contrast enema.**



**Figure 7. Instruments used in treatment of Polyps of the rectum and recto-sigmoid. In the treatment of polyps, one should have proper equipment. The proctoscopes should enable the passage of the electrocoagulating snare and the fulgurating electrode. An air suction should be available at the time of fulguration.**

barium and insufflating the colon with air after evacuation will bring out many polyps not visualized by the usual barium enema (Figure 6).

Polypoid disease can be treated by (1) Fulguration (2) Snare and fulguration (3) Clamping of pedicle with cauterization of the base (4) Excision with biopsy forceps with or without cauterization of the base (5) Excision with scalpel and suture of the base or (5) Colotomy (Figure 7).

The polyp that is found on digital examination and can be exposed outside the anal canal is treated in the same manner as a hemorrhoid. A suture is taken at the base of the polyp, the polyp clamped, excised and ligated with transfixion of the base. Polyps in a higher location, visualized on proctoscopic examination, are best treated by electrosurgery using either simple fulguration or electrocoagulation with the snare. If the entire polyp is not removed, then punch biopsy should be done. The amount of tissue fulgurated at each treatment depends upon the individual surgeon's judgment. Ordinarily, by this method, several treatments are necessary to eradicate the growth completely. Fulguration is a safe procedure and obviates the possibility of uncontrolled hemorrhage. Hemorrhage is most likely when the slough comes away especially from the fifth to the tenth day, during which time the patient should remain under strict observation. Sometimes small topical doses of radium are used to safeguard against hemor-

rhage. If the lesions are in close proximity to the vagina, uterus, urinary bladder, seminal vesicles, or prostate gland a modified fulguration technic must be used to insure against perforation. A general anesthesia is not given unless the lesions are extensive or deep seated since the co-operation of the patient is desirable.

The electrocoagulating snare can be used in the treatment of polyps within ready reach of the proctoscope but should be used with caution. Pedicles of polyps may contain large arteries and sometimes uncontrolled hemorrhage may occur. The long pedicles may be part of the colon wall and removal with a snare may cause perforation of the bowel.

Single polyps that are beyond the reach of the proctoscope are best treated by the abdominal route. Colotomy is performed with excision of the polyp and suture of the base provided the lesion is benign. If there is question of malignancy resection should be done. Frozen section should be available at the time of surgery. If there is any evidence of malignancy, resection not only removes the lesion more adequately, but also the lymphatic area and prevents recurrence.

The treatment of multiple polyps is fulguration and electrocoagulation of the lesions in the rectum with colectomy and ileosigmoidostomy provided the rectum is free of cancer and adequate follow up is feasible. The procedure must not be performed if there is any question of cancer in the rectum, if the rectum cannot adequately be treated by fulguration and electrocoagulation, or if the patient will not agree to remain under careful treatment for the rest of his life.

Considerable debate still exists as to the proper treatment for certain types of malignant polyp. If there is invasion of the submucosa radical resection is definitely indicated. The results of treatment of polypoid disease is quite gratifying if these principles are carved out. Swinton<sup>5</sup> recently reported the treatment of 400 cases of *benign* polyps with only 6% developing a recurrence or cancer. Malignant polyps treated locally do not show such good results. Lockhart-Mumery and Dukes<sup>7</sup> have reported 47 solitary malignant rectal polyps treated locally and of these 23 or 50% recurred. McLanahan et al<sup>8</sup> have reported 38 malignant rectal polyps treated

by local excision with fulguration and of these 5 developed simple recurrence, 5 frank adenocarcinomas and 3 of these died of metastatic disease.

Ileosigmoidostomy for diffuse polyposis has proved quite satisfactory if rectal cancer is absent and adequate follow up studies are possible. Of 27 cases reported by Smith and Hill<sup>9</sup> none died of rectal recurrences although one died from recurrence secondary to a colon cancer removed at time of colectomy.

We have presented a general review of the problems of polyposis of the colon and rectum. A close association of cancer and polypoid disease is undeniable. (Figure 8). If polypoid disease is diagnosed early and adequately treated then we are not only preventing, but also curing neoplastic disease of the colon and rectum at its earliest stage.

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**Figure 8. Polypoid disease of the rectum in association with an early polypoid cancer.**

# The Washington Office of the A. M. A.

Frank E. Wilson, M.D.

When Alice, in her journey through the looking glass, remarked that it was strange considering how fast they were running that they appeared to be getting nowhere, the Red Queen replied, "It takes all the running you can do to keep in the same place." None of us really wants to remain in the same place, but we do have a sense of bewilderment in keeping up with the extraordinary advances of medical science and particularly with the socio-economic and political changes which confront us. We may take comfort in placing our feet squarely on the ground and realizing that the laws of nature and of social behavior have not changed much and, when we approach a problem such as a problem for the health of the nation, we know that there are certain things we can do. The excellent pamphlet, outlining a program of public relations for county medical societies which your committee has published, lists all of them.

Twenty years ago it was hardly likely that a lobbyist for the medical profession would have been invited to speak at your annual meeting here in Chicago. In fact, there were very few medical lobbyists anywhere. It was unheard of for a member of the profession to be so close to politics as to be stationed in Washington on a full-time basis to report the goings on there — and to inform Congress of the opinions of physicians. What brought this about was the beginning of a social revolution which is still going on — and it will probably go on for some time. During revolutionary times there are many forces at work and many groups demanding to be heard. Perhaps it is Darwin's theory again being proved that the fittest survive. Washington, D. C. because the maelstrom of the collective forces and those groups demanding to be heard. Some voluntarily, some through necessity. It was to protect the interests of physicians and their patients, and to exercise a rightful leadership, that the American Medical Association ten years ago established a Washington

office. (At first it was a listening post and now it is an action station as well.)

You physicians were probably taught in medical school, as I was, that medicine and politics don't mix. They still don't mix if you mean partisan politics. But we live in a political world and we cannot escape it. Nor should we shun politics. It is the most vital part of democratic society. Politics is here to stay. As intelligent persons in a representative government, it is up to us, first as citizens and second as doctors of medicine, to participate in the making of laws and the election of law-makers.

As a representative of the AMA, I am not speaking tonight of those things that deal with putting a particular candidate in or out of Congress. You can do that as citizens of Illinois, but not as members acting on behalf of a medical organization. What you can do is discuss with each candidate his views on the issues important to your practice of medicine and to let him know the way you think it should be practiced. We want our success, and our competence, to be measured by our colleagues and our patients, and not by federal bureaucrats.

Well, I am a registered lobbyist. Tonight I hope to give you a very brief account of the Administration's health program and the policy of your national Association in relation to it — from a lobbyist's viewpoint.

Just after the last national elections, I selected Chicago for a regional conference of central states to learn a little more about the men whom you had elected to Congress — and perhaps why in some cases — and to swap information with representatives of these state medical societies about the medical issues likely to come up in the 83rd Congress. As in most of the other regional conferences, a doctor came up to me and said, "Wilson, your job will be easier now that Truman and Oscar Ewing are out of the way, won't it?" My stock reply was that sometimes it is harder to work with your friends than with your enemies. One of the reasons I'm back in Chicago tonight is to repeat, after a year and a half, that it is more difficult to work with your friends.

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Presented before Public Relations Meeting at 1954 Annual Meeting, Illinois State Medical Society, Chicago, May 14, 1954.

The AMA, in December 1952, formed a liaison committee of its top elected officials to work with and assist in every way the newly appointed department heads, the Congress, and the President himself. The committee met with Mrs. Hobby on Feb. 4 last year and the next day was received by the President. We have seen Mr. Eisenhower more than on this one occasion, as you know. The committee spent weeks, not days, in Washington making overtures of cooperation and personally meeting all the leaders who have any direct influence on the medical profession — including Admiral Radford, chairman of the Joint Chiefs of Staff. We saw him at the suggestion of the President because Mr. Eisenhower thought we should get his views on medical care for the dependents of military personnel, and that he might benefit from ours.

It seemed to me that after 20 years of the closed door policy, the new administration would hang a lantern in the window, and put a welcome mat at the front door for the doctors. I think it is accurate to say that Mr. Eisenhower has done this, but not all the high ranking officials have followed his lead. I hasten to add that I believe their reaction is without the knowledge of permission of the Chief. We called it the "canvas curtain" and it was lowered, we thought, by too many hold-overs from the last regime. This year things are a little bit different, but the curtain is never out of sight.

The Secretary of the Department of Health, Education, and Welfare last year appointed a medical advisory committee from physicians suggested by the AMA liaison committee. She has not once called this committee together, in spite of the fact that her own experts sat down and planned for the compulsory inclusions of physicians under Social Security. This step was taken with the Secretary's whole-hearted support. Whether you agree that you should be covered is not the point here. It is that the profession is being ignored. Not one single M.D., other than a government employee, sat in on the several meetings that resulted in this decision.

The present Administration had no positive health program its first year. 1953 was a year of adjustment and realignment with the first half of the year spent under a Truman budget. During December of last year, Cabinet members and

heads of independent agencies had formulated plans for their respective departments, then met together in a series of meetings out of which came the Administration's policies and legislative program. This program was announced to the public in a series of special messages to the Congress in January of this year. The special health message was delivered January 18th. Bills have been introduced covering all major points and in addition, a few extra bills are under consideration supplementing the program.

It is now over half way through the second session of the 83rd Congress and hearings have been held on practically all these bills and a prognosis may be ventured on most of them.

All of you have heard that the major health program is reinsurance of voluntary health plans. This bill has an interesting background which is not generally known. In June of 1950 Congressman Wolverton of New Jersey, then a minority member of the House Interstate and Foreign Commerce Committee, introduced a bill proposing a federal corporation, similar to the one now in existence which reinsures banks against certain losses, for reinsuring voluntary non-profit health insurance plans. His bill, introduced late in the Congress and not important to the House leadership, received no committee consideration, I asked Mr. Wolverton at the time if the idea was his or somebody else's. This was one of my early blunders as a lobbyist — you never ask a Congressman if the idea he incorporates into a bill is somebody else's. He told me that he was fully capable of developing his own ideas. I learned later in the year that the idea came from Harold Stassen and that certain Blue Cross people had encouraged Mr. Wolverton. This was confirmed early this year by Mr. Wolverton in a conversation with me in his office.

What we are dealing with now, good and bad, is the Eisenhower administration's long-range health program. As I have indicated, most of it was not drawn up until last fall and early winter. It is not, I want to emphasize, it is not something that we have to be concerned with only for this session of Congress. The parts that are not passed now will be reintroduced in the next Congress. Even if there is a change in control of Congress after next fall's election, the Eisenhower administration will press for these bills, and there is no question that they would have

the support of many, many Democrats.

Obviously, the administration could not ignore the subject of health insurance. It would be expedient to come up with something appealing to a large segment of the population and yet different from compulsory health insurance. With Mr. Stassen high in the official family and the word reinsurance sounding like free enterprise, it was adopted as the keystone of the administration's health program. Apparently no one seriously considered defining the word in terms of action, in terms of government, or in terms of political involvement, until it was mentioned by the President in his message on the state of the Union.

The whole AMA Board had met in regular session in Washington in February and had hoped that the bill would have been introduced by that time. The Department of HEW had expected to have it ready, but on checking with the life insurance industry, was amazed to find serious objections to the bill because it put government into the field of insurance, in competition with private industry, and would not accomplish what it set out to do. By this time officials of the American Medical Association had had many discussions with all types of insurance people, bankers, industrialists, allied trade organizations, and professional groups. Many of these representatives appeared before a special meeting of the Board of Trustees held in Chicago for this very reason — all prior to the actual introduction of the bill. No position is ever taken on a bill until it is introduced, in spite of the fact that we are repeatedly asked to fall into a trap by stating our position before we see the words and understand their meaning. As soon as the bill was introduced, our Committee on Legislation and the Executive Committee of the Board of Trustees met jointly in a special session so that a position could be taken on this bill.

The only position that the AMA could take after so careful a study was that we are in accord with the stated objectives, but must oppose the federal government's methods of reaching them as stated in the bill. In my opinion, the administration would have to do some magical maneuvering to get the bill made into law this year.

Now, just about every time we oppose a major bill somebody always asks, Why, does the AMA always oppose everything? Why don't they come forward with an alternative? The answer lies in the fact that the AMA is one of the few national organizations which does not ask favors from Congress — and wants no federal money. A more succinct explanation was given to me the other day. I was reminded that nine of the Ten Commandments started out with, "Thou shalt NOT..." One of them says, "Thou shalt not commit adultery," — and the Bible does not suggest an alternative! Actually — although you don't see much of this in the press because it isn't sensational — actually the AMA supports almost every other bill of consequence in the Eisenhower health program. Not a part of the President's program, but strongly indorsed by the AMA, is the Jenkins-Keogh bill which would end tax discrimination against the self-employed and allow them more adequately to provide pensions for themselves without dependence on Uncle Sam. That is our alternative to social security for physicians.

Another major bill proposes an extension of the Hill-Burton law to include hospitals for the chronically ill, nursing homes, rehabilitation centers, and diagnostic or treatment centers. The AMA approves this bill in principle and has offered some perfecting amendments along with those of the American Hospital Association, which are being seriously considered by Congress and will probably be enacted into law. We are somewhat concerned that the definition of "diagnostic or treatment center" be spelled out more clearly and regardless of the definition, that they be operated under the supervision of an accredited hospital. We expect that this will be the first health bill to be passed. It has already passed the House.

A new formula for giving public health grants to states is another proposal which has the support of the AMA, generally speaking. This proposal eliminates categorical grants for specific disease and leaves it up to the state authorities to say what public health program the money will be used for, with the exception of mental health. One section of the bill grants the Surgeon General too much liberty in a "unique projects" grant. He has the authority already, but this section is simply a gimmick to get more money

out of the appropriations committee. We objected to this provision as being unnecessary but feel that even with it, the bill has merit.

The AMA has never taken a position for or against social security, as such. It does object to the compulsory inclusion of physicians under this program. It does not object to the voluntary coverage of physicians, as is being proposed for educators and religious leaders. I am aware that in some quarters of the profession there is opposition to this position of AMA. My only answer to that is, that the majority rules. Another objectionable proposal in the social security amendment bill is a waiver of premium for permanent and total disability. We object to this on the grounds that it is not necessary, and that it would unnecessarily involve physicians by requiring them to make federal decisions on patients whose conditions may be considered permanent today, but tomorrow, with newer therapy, may be completely recovered. The federal government could exercise a remote control over doctors. On this point we have an alternative because we believe that persons who are in need of social security benefits due to disability should be given consideration. This could be done by computing the 5 or 10 best years of a person's working record and grant benefits on this basis. This method would be cheaper in administration, and could cover such other conditions as unemployment and other justifiable and unfortunate situations. The Department of HEW is looking kindly towards using the 4 years of least earnings and computing the benefits from that. I am not an economist and do not understand the difference, unless the Department does not want labor to say the Department is the tool of the AMA.

Deductions from income tax for medical expenses is a small provision in the huge bill which proposes a revision of the income tax law. We have actively supported this idea for a number of years, and have encouraged some Congressmen to take the lead in sponsoring this legislation in separate bills. We have heard no one object to this proposal. The administration did not consider that this was part of a health program, and so I hereby gratuitously credit it to the Eisenhower health program anyway!

The latest health proposal came from the Defense Department. The bill proposing an ex-

tension of medical care for the dependents of military personnel has only recently been introduced in the Senate. There is no House bill yet. This bill follows the recommendations of the Moulton Commission report of last year. Essentially it suggests that dependents of military personnel be given medical care and hospitalization whenever possible in military hospitals. If military medical care was not available, they would receive such care from civilian sources with the federal government paying directly all beyond the first \$10, and perhaps more than 90% of the total bill.

The present situation as regards dependent care is, that the three services have no united, or equal, regulations on this subject. The army leaves it up to the commander of a hospital as to the extent of beds and facilities he can make available — beyond those necessary for soldiers.

The AMA is not opposed to military dependents getting medical care if they are really dependent, and are the soldier's immediate family. Our thinking conflicts with military thinking in one or two areas. We believe that this bill would encourage the military to bring dependents into military hospitals, resulting in a shortage of beds for the military, and a shortage of medical officers to care for them. This situation always has a great appeal to Congress because it involves the strength of the nation, and it is a rare Congressman who would vote nay to any such thing. This is not idle thinking. It is exemplified in the overgrown Veterans Administration hospital program which started the same way. We do not want another doctors draft to take care of dependents, when there are ample facilities for them, as for other citizens. We are in agreement with the Defense Department that the military hospitals overseas, and in isolated places, should treat legitimate dependents. There is a need for unifying the regulations of the Army, Navy, and Air Force on this subject, but it is not necessary to expand the military medical care program to take care of these dependents. Except in rare cases, they can be cared for in civilian hospitals and by civilian physicians. That is the major difference between the AMA and the military — should most of these civilians be treated by civilian or by military personnel and facilities?

I think it can be safe to say that there has

been a change in the federal government in its attitude towards health. The present administration is honest in its motives, but a little too desirous of pleasing everybody, including those who have been so well pleased for 20 years. The AMA has made every effort we knew, to be helpful, to steer the present leaders away from the socialization of medicine, and it has been, and is a rather difficult job, to educate your friends on what is socialization. American medicine stands ready always to offer what assistance it can to the progress of medical science and art, and to the application of the finest medical care to more people, at the lowest cost. In order to defend the right of American physicians to organize themselves into a common purpose to bring about the finest medical care anywhere, the AMA had to be informed of those "isms" which were rampant in Washington at that time. We have won a partial victory. I am happy to say that the scope of the Washington Office and that of the entire medical profession has broadened. We want to be as helpful as possible to the federal government so long as the rights, guaranteed by the Constitution are kept intact, and the dignity of medicine is respected.

Your medical representatives in Washington are conscious of the fact that we represent you through the democratic system which the physicians of this country have set up. We must represent the collective thinking of medicine and especially the state medical societies. You cannot leave it up to us entirely to fight for good legislation and against bad. Your contacts with Congressmen here in Illinois are far more

effective than ours there in Washington.

I am frequently asked by physicians to summarize the complaints Congressmen give me about the medical profession. Some of them are: (1) the high cost of medical care; (2) inability to get a doctor in an emergency; (3) shortage of doctors in rural areas; (4) doctors are not civic minded enough; they don't join in community efforts; (5) they are too politically minded; (6) they are not politically minded enough; and (7) doctors are selfish and self-centered.

This summary forms the basis of most of the complaints we hear in Washington. Answering these complaints is a trying ordeal. You know as well as I do that in most cases, the complaint is unjustified, but nevertheless, it must be answered. I pass on to you the thought that if these complaints do persist, whether justified or unjustified they affect legislation, and will eventually color the practice of medicine not only for us, but for our children. The profession has a marked responsibility. You should not permit lobbying to be limited to the Nation's Capital. The most effective lobby is your contacts with your Congressional representatives.

There is too much thinking by the Congressmen in Washington that the American Medical Association is solely a political organization. If we accent the positive from back home as well as from your national Association — that the good deeds of American medicine are predominantly scientific and cultural and for the benefit of the public — we won't have to fight too much bad legislation because there won't be so much.

# Certain Antibiotic Hazards

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The various scientific developments in the field of antibiotics have unfolded for us ever widening horizons and what appear to be ever greener pastures. The current list of substances in the antibiotic armamentarium (Table 1) is used almost universally, in some way, in every field of medicine. The chief untoward or toxic reactions of the commonly used antibiotics are well known (Table 2). Despite the justifiable confidence and satisfaction of the medical profession in the tremendous and at times almost miraculous success of these agents, it is necessary to remark very pointedly that we must continue to develop new agents in this most essential field of therapy. There are several compelling reasons for making such a statement. The first of these is the clear-cut fact that in the area of infections represented by the viruses, we have produced, for practical purposes, no successful antibiotic. In the field of the infections due to bacteria there is ample evidence that a rather widespread and in some instances an alarming resistance develops in certain supposedly susceptible organisms. This is especially true with different species of staphylococci and micrococci. In addition, the manifestation of certain toxic or hypersensitivity reactions by many patients, to certain of the antibiotics, is also a cause for much serious consideration.

I would like to provide my own answers to the following three questions. They should be considered as my personal opinions and those of a scientist first and a clinician second.

Is changing resistance of *organisms* to antibiotics a fact and if so, to what degree is it of practical significance?

Does so-called "superinfection" or over growth of nonsusceptible organisms, constitute a problem?

Are combinations of several antibiotics of established clinical value and are there any hazards connected with such combinations?

To answer the question as to whether resist-

TABLE 1: ANTIBIOTICS COMMONLY USED

<i>Systemic and Topical (unquestioned)</i>	<i>Topical and Possibly Systemic</i>
Penicillins	Bacitracin
Streptomycin (Dihydro)	Polymyxin
Chloramphenicol	Neomycin
Aureomycin	Viomycin
Terramycin	
Erythromycin (?)	<i>Topical only</i>
Carbonycin	Tyrothrycin
	Gramicidin

TABLE 2: CHIEF TOXIC REACTIONS

<i>Antibiotic</i>	<i>Undesirable effects</i>
Penicillins	Hypersensitivity
Streptomycin (Dihydro)	Neurological (8th nerve)
Aureomycin	G-I disturbances
Terramycin	G-I disturbances
Chloramphenicol	G-I disturbances
	Bone marrow (?)
Bacitracin	Kidney damage
Polymyxin	Kidney damage
Erythromycin	G-I disturbances

TABLE 3: COMMONLY USED COMBINATIONS

<i>Indication</i>	<i>Combination</i>
Resistant Staphylococci	Penicillin and Streptomycin
Subacute Bact. Endocarditis	Penicillin and Dihydrostreptomycin
Meningitis (Bacterial)	Penicillin and Sulfonamides
Brucellosis	Dihydrostreptomycin Aureomycin, or sulfonamide
Tuberculosis	Dihydrostreptomycin & PAS & Isoniazid
Mixed infections	

ance of organisms to antibiotics develops we may quote the data from the studies which are available<sup>1,2,3</sup>. Present surveys, for instance, indicate that some 60% of staphylococcus aureus and staph. albus strains are resistant to penicillin by test tube studies. Several years ago, similar studies, although not extensive, indicated 20-30% incidence of such resistance. Again, from what short term studies as are available, it is also apparent that there is increasing resistance of

From the Stritch School of Medicine, Loyola University, Chicago. Presented at the Post Graduate Conference, Centralia, April 2, 1953.

organisms to the broad spectrum antibiotics, aureomycin, terramycin, and chloramphenicol<sup>4</sup>. This development of resistance is not an invariable phenomenon with all organisms. There is a widespread difference in the individual species. Some, such as the staphylococci and mycobacterium readily and widely develop resistance. Others, like treponema pallidum seem to be relatively prone not to develop resistance.

A further problem in the development of resistance of bacteria is this: if an organism becomes resistant to one agent is it also resistant to any or to all other antibiotics? The answer here is that widespread cross resistance does *not* commonly develop. This means that an organism which is resistant to penicillin, for instance, is not likely to be resistant to streptomycin or to terramycin. In general, however, there may be some change toward decreased sensitivity to several antibiotics but not generalized significant cross resistance. It is also important to recognize that from this standpoint, we can divide the widely used antibiotics into two classes, — I. — penicillin and streptomycin, and II — aureomycin, chloramphenicol, and terramycin. In a final word on the matter of resistance, we can say that it is a problem of serious importance to the practicing physician, especially in the light of the common practice of giving antibiotics for any and all aches, pains and ills. We thus set up and encourage antibiotic resistant organisms — even though they many not be an important factor in the disease which is being treated at the moment.

I will begin my consideration of the problem of “superinfection” or of overgrowth of non-susceptible organisms by giving you a summary from a recent published case.<sup>5</sup> A typical case of pneumonia was seen with a throat culture which showed primarily *Klebsiella pneumoniae*. Under combined therapy with penicillin, dihydrostreptomycin, and aureomycin, normal temperature was not obtained until after seven days. On the eighth day the patient again became worse and the x-ray picture was that of a spreading pneumonia. At this time cultures revealed practically pure *Pseudomonas aeruginosa*. In vitro tests indicated marked insensitivity to penicillin, dihydrostreptomycin, aureomycin and chloramphenicol. However, test tube inhibition was noted with 1.9 micrograms of polymyxin B per ml. Therefore, the previous therapy was discontinued and

50 mgm. polymyxin B, intramuscularly, every 6 hours, was begun. There was gradual improvement and after 8 days the 6 hourly dose was reduced to 25 mgm., and continued for a total of 15 days. The recovery was slow but uneventful. Cases similar to this have also been well documented where proteus organism was involved.

The reports of serious infections where non-susceptible organisms are involved are certainly increasing. It is not possible to state authoritatively that such cases as that described above are fostered or encouraged by antibiotic therapy. They certainly are coming more and more to our attention than was the case before the advent of antibiotics. But it is not possible to conclude, definitely, that inhibition of organisms such as staphylococci and other cocci by antibiotics actually promotes clinical infection by companion but non-susceptible organisms such as proteus and pseudomonas. Rather than promoting or forstoring such infections, antibiotics may merely unmask them.

As a part of the problem of “superinfections”, we must consider whether or not fungus infections are increasing as a result of antibiotic therapy. In specific terms, have monilia infections increased as a result of widespread antibiotic therapy? *Candida albicans*, one of the monilia group of yeast-like fungi, regularly emerges in abundance in the mouth and gastrointestinal tracts of those receiving antibiotics, especially the so-called wide spectrum antibiotics<sup>6</sup>. The resulting signs and symptoms are mostly a product of mucous membrane irritation. They include sore mouth and throat, stomatitis, glossitis, black, hairy tongue, perleche, diarrhea and various pruritic manifestations. We should emphasize here that several diseases such as vitamin deficiencies, allergic reactions, bacterial and viral infections, as well as primary irritation, may produce these manifestations. The mere isolation of a monilia, which since it is resistant to antibiotics may merely have been permitted to flourish in the absence of its competitors, should not necessarily lead to a diagnosis of moniliasis. The development of a resistant and/or non-susceptible flora is a regular and expected consequence of antibiotic therapy. In the overwhelming majority of cases, the elimination of susceptible organisms and their replacement by non-susceptible ones is of no real clinical significance.

There are, however, probably more cases of thrush seen now, especially in older and debilitated patients. Similarly, infections due to antibiotic resistant gram negative organisms, especially *Escherichia Coli*, *Proteus*, and *Pseudomonas*, almost regularly occur in patients who are chronically ill and with very low resistance. This represents the emergence of the resistant or non-susceptible flora as a concomitant of general debility and antibiotic therapy. In addition, the literature has been reporting an increasing number of small but well documented cases of generalized, fatal moniliasis. They are usually related to and occur more commonly among those patients who have received prolonged antibiotic therapy.

In answer to the direct question, therefore, does overgrowth of non-susceptible organisms, bacterial and mungal, constitute a problem? We must say yes, but it constitutes a comparatively minor one, which is most important in debilitated and aged people.

In considering the third general question which I wish to bring to your attention, the problem of combinations of antibiotics, it is not possible to give any detailed guidance. We can only consider the general aspects of the problem. It is well established, both in the experimental animal and in human clinical material, that certain combinations of antibiotics result in a more successful form of therapy than either one alone.<sup>7,8</sup> Table 3 lists a few selected examples of this type of combination. One or two generalizations may be made concerning this phase of antibiotic therapy. In addition to the potentiation of effect as seen when several antibiotics are given simultaneously, there is some evidence that under certain specialized conditions, actual antagonism between antibiotics may result. This is especially true between the broad spectrum antibiotics when used with either penicillin or streptomycin. There is very little clear cut clinical data available on this subject. The report<sup>9</sup> where 14 patients with pneumococcal meningitis, treated with penicillin alone resulted in a fatality rate of 21%, whereas alternate patients, who were given the same dose of penicillin plus aureomycin, had a fatality rate of 79%, is about the extent of the clinical data available. Animal experiments, primarily in mice,<sup>10,11</sup> also lead to the same conclusion, that actual antagonism between two antibiotics may result under certain

experimental conditions.

To avoid antibiotic antagonism, at least as far as we know at the present time, avoid combinations of the broad spectrum antibiotics with either penicillin or streptomycin. If any combinations are used, give at least an adequate dose of each of the antibiotics, since actual antagonism appears to be favored when one of the antibiotics of a particular combination is given in a relatively small or ineffective dose.

These pessimistic and discouraging notes on the several hazards which are apparent on a careful analysis of the use of various antibiotics do not mean that one should give up the use of these agents entirely. Similarly, they do not mean that superinfections or resistant organisms will eventually necessitate that we discard our antibiotic agents as useless. In the same vein, this has not been presented to indicate that each and every patient or each and every antibiotic will exhibit one or more of these problems. Rather, it has been an endeavor to bring a word of caution in respect to antibiotics, and to bring a word of warning, so that forewarned one might better understand and cope with the problems as they arise.

## SUMMARY

Resistance of organisms to antibiotics is well established and should be considered carefully in clinical evaluations of their use.

Overgrowth of non-susceptible organisms or incidence of superinfections appears to be an increasing threat in antibiotic therapy.

Combinations of several antibiotics certainly are of definite clinical value. The question of possible antagonism between the simultaneously administered antibiotics must be carefully considered in many instances.

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# CASE RECORDS OF THE COOK COUNTY HOSPITAL

KARL MEYER, LEO M. ZIMMERMAN, DEPT. EDITORS

## The Control of Bleeding in Disarticulation of the Hip by Ligation of the Common Iliac Artery and Vein

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The control of hemorrhage and the prevention of shock in major operative procedures on the lower extremity poses interesting problems which have been the subject of wide discussion. The patients under consideration for such procedures are often so debilitated and anemic from malignant disease, involving the bone or soft parts in the upper end of the thigh or from severe crushing injuries, as to be unable to withstand any surgical operations that might entail any great loss of blood. The most serious blood losses are encountered in disarticulation of the hip and in hemipelvectomy.

The early methods of hemostasis have become obsolete and now are only of historical interest. Among these are the various forms of mechanical pressure exerted externally or by combined externally or by combined external and internal means, such as: a) pressure on the lower end

of the aorta by a Lister's tourniquet; b) pressure on the common iliac artery against the brim of the pelvis by a Davy's lever introduced into the rectum; or, c) the Momburg's belt, an even cruder method, consisting of rubber tubing passed tightly several times around the lower abdomen<sup>1</sup>. Other methods consisted of direct attack on the major vessels, such as: a) ligation of the femoral artery, before the flaps were cut or while they were being formed in the anterior racquet incision; b) digital compression of the femoral artery by the surgeon or assistant before the vessels were cut, the fingers being introduced beneath the vessels and compressing them against the thumb; c) temporary compression of the common iliac artery by the fingers of an assistant through a McBurney incision; d) rubber tourniquet pressure exerted around the extremity by (1) Wyeth's skewers introduced in the upper end of the thigh; (2) a Trendelenburg rod placed beneath the femoral vessels; (3) a Thomas forceps catching the vessels in the upper

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flap, or (4) by the rubber tubing method of Senn in which he passed the tubing through the tissues subcutaneously and tightened it externally by forceps<sup>2</sup>.

Judin<sup>3</sup>, in 1936, advocated preliminary ligation of the great vessels in order to lessen the blood loss. He warned, however, that ligation of the common iliac artery might result in necrosis. He quoted Brzovski, who reported twenty-six cases of ligation of the vessels in the literature and found necrosis of the flap in five. Sugarbaker<sup>7</sup> also discussed ligation of the common iliac vessel and warned about the danger of necrosis of the posterior flap.

George T. Pack<sup>4</sup> and his associates in 1946 reviewed the surgical technique of hemipelvectomy, with special reference to the control of hemorrhage, and added seven cases of their own. The seventh case healed per primam without any necrosis of the posterior flap. Wise<sup>5</sup> advocated temporary control of the common iliac artery during the operative procedure by a temporary tape ligature around the artery, which is released at the conclusion of the operation. Brittain<sup>6</sup> reported five cases of hemipelvectomy, in two of which the common iliac artery was ligated instead of the external iliac artery, making the operation much easier though some sloughing occurred in the anterior part of the flap.

In the case herein reported, both the common iliac artery and the common iliac vein were ligated without any necrosis of the flap. In each instance a single ligature was used.

Cook County Hospital Case No. 16423, a 68-year old female, was admitted on March 24, 1952, with a history of having been in good health until three months before admission, at which time she had fallen on a waxed floor. Immediately after the accident, she noticed pain in the right thigh. This had become progressively worse, and she was unable to walk without severe pain. The thigh was painful to the touch and also on turning about in bed. She believed she had lost about ten pounds of weight in three months and also had experienced a loss of appetite.

Her family history was noncontributory. She had had an appendectomy in childhood. Menopause had occurred in 1932, twenty years before admission. Her physical examination was negative except for the right thigh which was two

and a half times larger than the left. A large mass occupied the antero-lateral surface. The mass extended from approximately 8 cms. above the patella to within 10 cms. of the inguinal fold. The mass was resilient, smooth and slightly tender on pressure. The overlying skin was not fixed; the mass was adherent to the deeper structures. Her temperature at time of admission was 98.6° F., pulse was 72, respiration was 22, and blood pressure was 120 systolic over 80 diastolic. Her laboratory workup was as follows: N.P.N., 40 mg. per 100 cc.; thymol turbidity, 1.8 units; cephalin flocculation, 0; gamma globulin, 1.1 mg. per cent; total serum protein, 5.9 gm. per 100 cc.; albumin, 2.9; inorganic phosphorus, 4.2 mg. per 100 cc.; alkaline phosphatase, 5.4 units per 100 cc.; icterus index, 6 units; Kahn test, negative. The patient's blood count showed 75% hemoglobin with 12,300 white blood cells.

X-ray of the right femur (See Figure 1), done on March 26, 1952, was reported as follows: "A-P view of the right hip and proximal half of the thigh laterally. The underlying cortex appears thin and irregular. There is no evidence of calcification of the mass, nor is there evidence of periosteal reaction. Impression: Large, soft tissue mass of the thigh with thinning and irregularity of the underlying bony cortex. Among

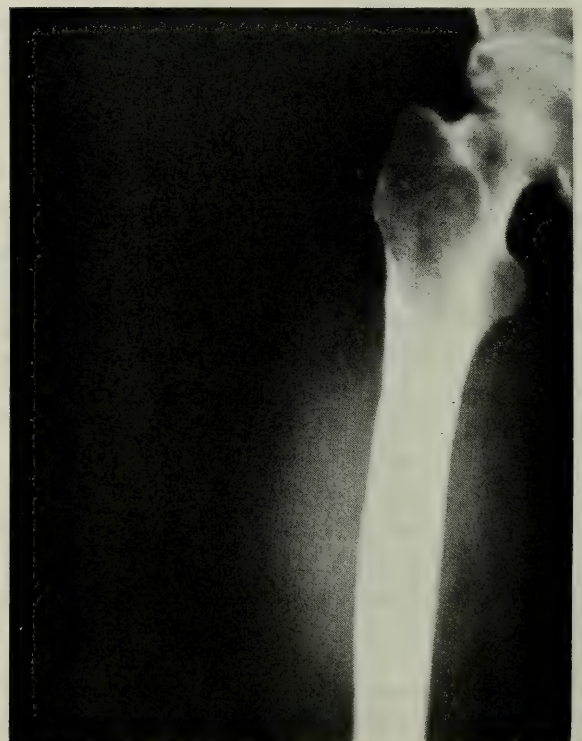
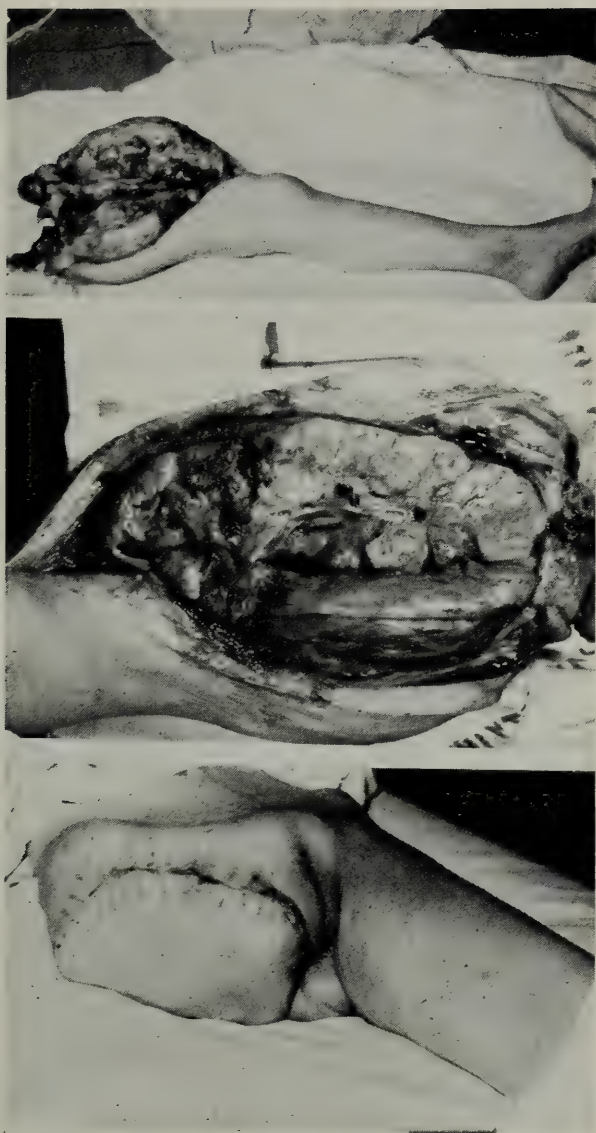


Figure 1.



**Figure 2 (at top) showing hip joint disarticulation.**

**Figure 3. (center) Close-up of tumor tissue.**

**Figure 4. (Bottom) Wound healing by first intention.**

other neoplastic entities, a nonossifying periosteal fibrosarcoma should be considered."

A chest film was reported as showing the lung fields were not remarkable.

Another x-ray of the thigh and pelvis was reported two days later as showing slight irregularity of the cortex of the femur on the lateral aspect of the shaft. The remaining osseous structure was not remarkable.

On April 2, 1952, an incision biopsy was done after an aspiration biopsy revealed only dark blood. A large quantity of serofibrocaceous material, which was very friable, was removed. A microscopic examination report was returned of a rhabdomyosarcoma with degenerative changes.

On April 4, 1952, a disarticulation of the right hip was done. Preliminary to the definitive treatment, a left paramedian incision was made, the right common iliac artery first ligated and then the vein. An anterior racquet incision was made through the skin, and a hip joint disarticulation was done. (See Figures 2 and 3.)

The patient lost very little blood and a transfusion, during the surgical procedure, was not necessary. There was no appreciable change in blood pressure or pulse rate during the procedure, and the patient left the operating room in excellent condition. Subsequent to the operation, the patient received a blood transfusion and experienced a severe transfusion reaction with a lower nephron nephrosis, during which time her temperature rose to 101° F., her urine showed 4 plus bile, 2 plus urobilinogen, and the presence of bile casts but no blood. The icterus index was 118; N.P.N., 59. The patient finally made a complete recovery and was discharged from the hospital on April 30, 1952.

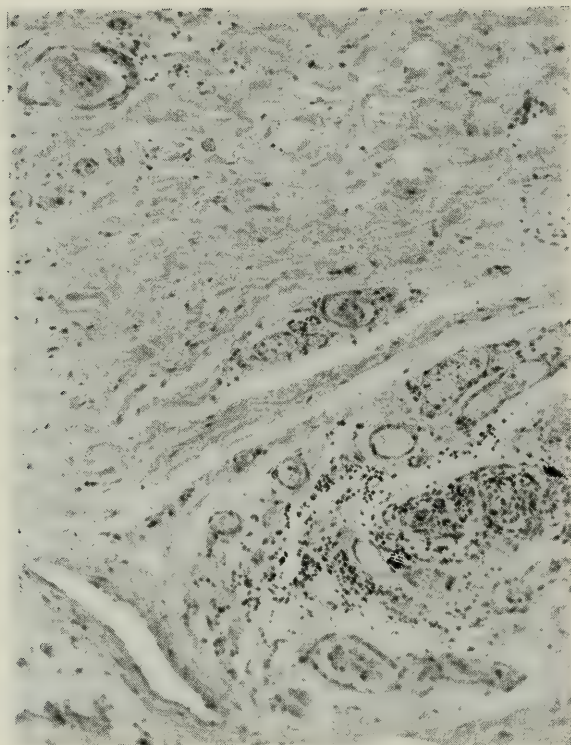
The pathological report, following disarticulation, was as follows:

"Specimen consists of a disarticulated right lower extremity including the hip joint. The color of the skin is white. A mass was located in the quadriceps group of muscles, measuring 23.5 by 8 cms. It was pale yellowish-red in color and has not actually invaded the anterior femoral surface. However, it has caused an inflammatory reaction on the periosteum. There is a cyst, measuring 7 by 7 by 4 cms., in the upper part of the mass. It contained a clear yellow fluid.

"Microscopic section of the tumor reveals a highly resilient tumor in which full signs of necrosis are seen. The tumor cells are very pleomorphic, in some areas being elongated with vesicular and hyperchromatic elongated nuclei. In other areas the cells are bizarre with very large hyperchromatic nuclei, containing large clumps of chromatin. Multinucleated giant cells are frequent. (See Figure 5.)

"Diagnosis: rhabdomyosarcoma."

This case is herewith reported because of the ligation of the common iliac artery and the common iliac vein without any subsequent necrosis of the flap. Both the artery and the vein were ligated by a single ligature. Humphries (8) has emphasized the fact that a single ligature on an undivided vessel will almost always permit ulti-



**Figure 5. 75 X Low Power of Rhabdomyosarcoma.**

mate reformation of the lumen. It is suggested that this might be a reason that no necrosis occurred, in addition to the fact that there may have been additional, collateral circulation from the other side.

## SUMMARY AND CONCLUSIONS

1. A case of disarticulation of the hip joint with preliminary ligation of the common iliac artery and vein is presented.

2. A brief review of the literature on methods of hemostasis in amputation of the lower extremity has been presented.

3. Confirmation has been added of the fact that ligation of the common iliac artery can be accomplished without necrosis of the flap.

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## BORIC ACID POISONING

Although boric acid has been in use for many years, it is only recently that it has been discovered that this drug may cause toxic reactions and even death. Boric acid poisoning has developed in infants particularly as a result of its topical application for the treatment of diaper rash. This drug, when applied to any open wound or exudative dermatoses, may if the surface is extensive, be absorbed by the transcutaneous route. The toxic symptoms include diarrhea and vomiting in the early stages, followed later by profuse,

bloody diarrhea and vomiting leading to dehydration, shock, cyanosis, and coma. Death may ensue within a few hours or after several days. Diagnosis is also confirmed by an intense erythema of the skin, mucous, and tympanic membranes, followed after a few days by a superficial desquamation. Treatment is supportive and consists of administration of fluids, oxygen, blood, and antibiotics. *Meyer L. Niedelman, M.D., Uses and Abuses of Drugs, New and Old, in Dermatology. Pennsylvania M.J. April 1954.*

## CASE REPORTS



# Prophylaxis of Hemolytic Disease of the Newborn with Cortisone

**Joseph B. Teton, M.D., F.A.C.S. and Nancy C. Treadwell, M.D.  
Chicago**

Hemolytic disease of the newborn occurs in one out of 200 full term pregnancies or in a ratio of 1 to 26 of the matings of an Rh negative female and an Rh positive male. In about 3 per cent it is the presumed cause of fetal death.

Various attempts have been made to prevent fetal erythroblastosis, among which may be mentioned a few that achieved short-lived popularity:

1. The use of vitamin E to decrease the permeability of the placenta so that it is more difficult for the antigens to reach the mother.
2. Methionine to prevent liver damage in the fetus.
3. Injections of ethylene disulfonate which is supposed to react chemically with the antibodies.
4. Replacement transfusions to sensitized mothers to dilute the Rh antibody.
5. Rh counter-immunization with typhoid or

tetanus vaccine; the stronger antigen suppresses the weaker.

6. Rh hapten is the specific reacting fraction of a complete antigen. It will combine with its own antibody but is not antigenic.

The most recent efforts center about the use of ACTH and cortisone. Opinions regarding the efficacy of this latest measure vary from complete disapproval to limited endorsement.

Mrs. D. Y., a 30-year old white, gravida II, para I, was first seen on February 26, 1953 when she was seven and one-half weeks pregnant. The previous pregnancy had ended at 28 weeks in the delivery of a premature infant which lived five days. She was Rh negative and her husband was Rh positive. The past history was otherwise non-contributory. The physical examination was negative except for the pregnancy and the routine obstetrical blood work was within normal limits. The prenatal course was uneventful until twenty-one and a half weeks when Rh antibodies were first found.

Because of the high degree of correlation be-

**From the Departments of Obstetrics and Gynecology, University of Illinois College of Medicine and Henrotin Hospital.**

**Presented at the meeting of the Illinois State Obstetrical Society held at Research and Educational Hospital, University of Illinois, January 14, 1954.**

# DEPRESSANT EFFECT OF CORTISONE IN ANTIBODY TITRE

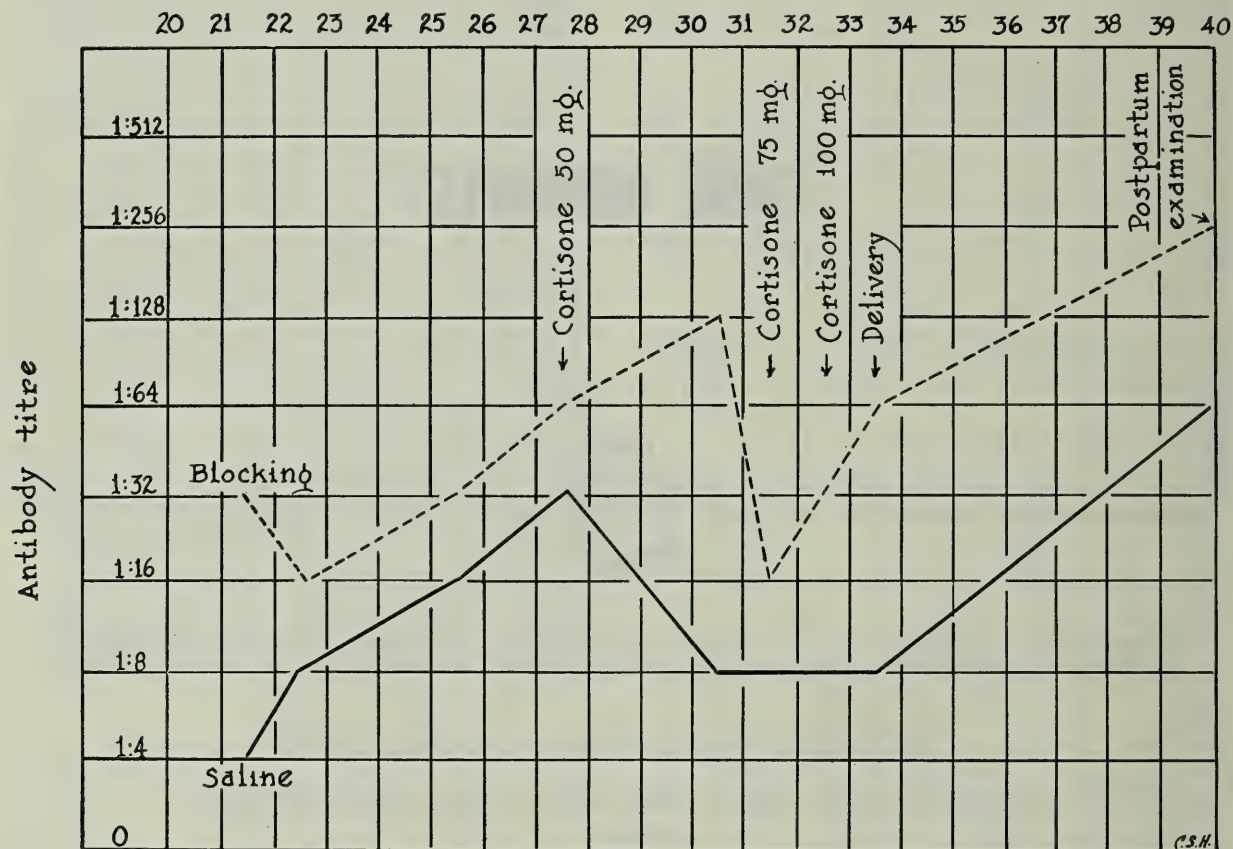


Figure 1

tween the maternal albumin agglutinin titer and the amount of this antibody which reaches the fetal circulation, and since severely affected infants may die between the twenty-sixth and thirty-fourth week of pregnancy, we decided to place the patient on cortisone therapy. The graph (Figure 1) shows the effect on the antibodies following administration of cortisone.

The pregnancy progressed to thirty-three and one-half weeks when, on August 25, 1953, the patient called to report a slight bloody vaginal discharge. She was instructed to go to bed. The bleeding increased, however, and she was admitted to Henrotin Hospital with a diagnosis of premature separation of the placenta with beginning premature labor and fetal distress. On August 26, she was delivered by low cervical cesarean section under local anesthesia of a living female infant, weighing about three and one-half pounds, in apparently good condition. The mother's postpartum course was uneventful. The dosage of cortisone was gradually decreased

over a three day period. She was discharged on the tenth postoperative day.

The baby was transferred to Sarah Morris Division of Michael Reese Hospital a few hours after delivery. The red blood count at Henrotin Hospital was reported as 1,000,000; however, a recheck count on arrival at Michael Reese Hospital showed 4,000,000 red cells, normal serum bilirubin and positive Coombs' test. The liver and spleen were not palpable and no obvious jaundice was noted. It was decided to attempt exchange transfusion immediately. The first attempt failed due to the small umbilical veins; the second attempt on the following day in the right femoral vein was also a failure. The baby was now grossly jaundiced and the serum bilirubin had risen to 12, although the red cell count was still 4,000,000. Subsequently the right leg became cyanotic and edematous. The Vascular Service was of the opinion that an occlusion of the right femoral artery had occurred, probably from an embolus; therefore, further attempts

at exchange transfusion were temporarily deferred. One day later the serum bilirubin was 18 and red blood count 4,000,000, so another attempt was made to the left femoral vein which was successful. The right leg then appeared improved; the red cell count remained at 4,000,000 and the serum bilirubin rose to 35. The following day the serum bilirubin dropped and there was no further rise.

From this point on the baby continued in relatively good condition from the erythroblastotic standpoint. Several small transfusions were given, starting on the sixth day of life, because of decrease in the red blood count (2,300,000 to 3,000,000). The right foot and leg developed gangrene, which was allowed to demarcate until it was almost ready to slough. On the twelfth day of life a debridement was done below the knee with a good flap of muscular tissue for a prosthesis. No anesthesia was necessary. The baby made a good recovery from this procedure, is now at home and seems to be making satisfactory progress. Evaluation of possible cortical damage from Kern icterus must be deferred until the baby is six months old and is functioning on a cortical level.

#### COMMENT

We feel that the severity of the erythroblastosis

was less than might have been anticipated in view of the early development of blocking antibodies.

While we fully realize that one case is not too significant, the problem of obtaining a healthy living child from a highly sensitized Rh negative woman is so difficult that any measure which might contribute in however small a degree to such a happy outcome is worthy of trial.

#### SUMMARY

This case seemed to demonstrate

1. a specific depressant effect of cortisone on the anti-Rh agglutinins;
2. that cortisone did not produce hypertension, edema, excessive weight gain, hyperglycemia or toxemia, or increase the postoperative complications;
3. the hazards attendant upon exchange transfusion by the femoral route.

30 N. Michigan Avenue

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## SURGERY FOR FISTULA

Fistula in ano usually requires complete removal of the fistulous tract to eradicate the condition. The tract or tracts usually pass external to the external sphincter muscle or between it and the internal sphincter, so that division of the external sphincter muscle only is required. Care should be taken to divide the muscle at right angle to the direction of the muscle fibers and to divide it only in one place to preserve anal continence. The after care of the wound is very important. Packs should be removed entirely the first time they are disturbed, usually at about 48 hours post-operatively, and rarely replaced. Sitz

baths are begun the day following operation and are continued two to four a day until the wound has healed. Pocketing is prevented by gently wiping the wound out to its bottom as often as necessary and by irrigating the wound with a 1:2,000 Zephiran Chloride solution. After a few days this becomes a painless procedure. A small wet Zephiran Chloride sponge dressing is placed over the wound and changed as often as necessary to maintain comfort. A Furacin dressing can be used for this wound. Neither Zephiran Chloride nor Furacin is irritating but occasionally a patient is allergic to Furacin. *R. Harvey Bell, M.D., Texas J. Med. Feb. 1954.*

## TRAUMA AND CANCER

I had occasion to review a symposium on the relationship of trauma to malignant disease, which was held at the University of Chicago four years ago. At this conference there were three doctors, two of whom were pathologists, and two lawyers. It is interesting to read the question and answer period because it is a highly debatable subject and has many medicolegal implications. In general, most medical men feel that we do not know the cause of malignant disease and, not knowing the cause, we cannot prove that trauma, a single trauma per se, causes malignant disease. The lawyers, on the other hand, feel that because you do not know the cause of malignant disease, you cannot disprove that trauma has some relationship and, therefore, you must give the patient the benefit of the doubt. The arguments against a single trauma being the cause of malignant disease are based on a statistical analysis of the incidence of trauma in this country. It is estimated that there are approximately ten million traumatic injuries occurring every day in this country, and these are primarily in children and young people. And yet the incidence of carcinoma or malignant disease is low in childhood and young adult life, and much higher in the older age groups. Furthermore, every single day in all the hospitals in the country, there are thousands of trauma performed in the nature of surgical operations. At no time has a neoplasm ever been proved to occur at the site of the operative incision. This is offered as evidence against the contention that a single trauma can be the inciting factor in neoplastic disease. Experimentally, for many years, pathologists have been trying to produce neoplasms by injuring various parts of experimental animals. They have fractured legs many times and have been unsuccessful, by means of one single direct trauma, in producing carcinoma. Also, in a patient with a known carcinoma, they have never been able experimentally to incite metastasis. In other words, they have never been able to injure a part at a distance and cause metastasis to occur at that site. So, in general, it is believed that trauma itself is purely coincidental and simply calls attention to the neoplasm in the patient. *Daniel Burdick, M.D., Clinicopathologic Conference, New York J. Med. April 15, 1954.*

## EXTRASYSTOLES IN OLD AGE

Heart rates over 100 (in old age) are not rare and occasionally much higher values are found without any discernible reason. In a series of 102 elderly patients without history of cardiovascular disease, eight had sinus tachycardia and another observer found sinus tachycardia in 16 per cent of his patients. A fast rate represents a strain on the heart. No specific therapy is available since digitalis does not reduce the rate in compensated patients and quinidine is useless. Therefore, sinus tachycardia persists for many months or years, occasionally subsiding gradually for unknown reasons. The appearance of auricular fibrillation is advantageous in these patients, who often suffer from coronary sclerosis, since the activity of the ventricles can then be slowed by digitalis.

All types of extrasystoles are more common in the older age group. Extrasystoles in patients over 70 may appear for years without any evidence of heart disease. They were found in 20 per cent of the inmates of a home for the aged; in another study of many elderly people, extrasystoles were observed in 31.9 per cent. In our opinion, ventricular extrasystoles are most common, but others believe that the auricular form is encountered more often. In elderly patients with coronary sclerosis, auricular extrasystoles are frequent precursors of auricular fibrillation. *David Scherf, M.D., Cardiac Arrhythmias in the Aged. Geriatrics, Feb. 1954.*

## TREATMENT OF OLD AGE

Perhaps one of the most useful contributions of gerontologic research over the past few years has been the demonstration that aging is not necessarily associated with disease and deterioration. In many studies, both in the physiologic and psychologic areas, it has been shown that many of our common beliefs about the impairments in older people are without basis in fact. For instance, it has been shown that with adequate protein, calcium, and vitamin D intake, older people are still able to form new tissue and to accumulate calcium in their bones. In the psychologic area, it has been shown that the decrement in intelligence with age is much less than had previously been supposed and that in superior adults, the fall in intellectual capacity is scarcely measurable. *N. W. Shock, Gerontologic Research. Pennsylvania M.J. April 1954.*

## EDITORIALS



### THE THREAT OF PULMONARY CARCINOMA

Arthur S. Webb, M.D.

Malignancies of the lungs are a great challenge. The incidence of lung cancer is at least equal to that of the stomach. The ratio of males to females is four to one. The etiology is unknown. The growth may occur anywhere in the lung. It may be in a major or lesser bronchus. It may result in ulceration and occlusion with atelectasis. Secondary infection may occur. Such an infection may be a simple pneumonitis, a bronchiectasis, or multiple abscesses. Recurrent pneumonitis is suggestive. More rarely obstructive emphysema may occur. A tumor in a small bronchus or at the periphery of the lung field may grow to considerable size before symptoms occur. The symptoms may vary according to the location of the growth and its direction of spread. A tumor of the hilum may involve a major bronchus with resulting cough — dry or moist with possible hemoptysis. If the growth penetrates the pleura, there may be pain from the pleura and intercostal nerves. The common symptoms are cough, hemoptysis, dyspnea, wheezing, pain and fever. It must be emphasized that there are no characteristic signs or symptoms. The patient may be completely asymptomatic. Unexplained persistent cough is suggestive of pressure. A cough of six weeks or longer, even in the presence

of a normal chest film, should be persistently followed until explanation can be made. This diagnosis which formerly was regarded as rare, today is common. Survey films and hospital admission films has emphasized the finding and importance of a coin shadow in the lungs. When an unexplained shadow is noted in a roentgen film of the chest, it may be necessary to utilize many further procedures such as: fluoroscopic study; roentgenograms at different angles; bronchoscopy with cytology of aspirated mucus; tissue biopsy obtained in bronchoscopy; bronchography; biopsy of a lymph node; biopsy of the pleura; on biopsy of the lung. When procedures fail to establish the diagnosis, exploratory thorocotomy should be done. The mortality of this operation is about the same as that of an appendectomy. The early diagnosis of a lung malignancy is important. Too many are discovered too late.

The family physician should encourage the taking of chest films at least annually in all people. Heavy smokers, and those exposed to some industrial irritants, should have films every three months. In this day with the less expensive scout film, there is no excuse for neglect of this problem. By doing this and being assiduous in the study of individuals with suggestive film shadows, the mortality rate of this carcinoma will be reduced. The increasing incidence is evidence

enough to warrant a persistent attack. The research now being done will eventually reveal the reasons for the increase and we may have further means of attacking this problem.

### **WE ARE 47TH IN PERCENTAGE OF AUXILIARY MEMBERSHIP!**

The Illinois State Medical Society is proud of its Auxiliary. The Society has learned never to underestimate the power of the women. They have contributed of their time and money to the Benevolence Fund. They have assisted in all county public relations programs. They have contacted their congressmen and expressed their opinions on legislation affecting their husband's profession. They have "manned" the State Society booth at the Illinois State Fair and at county fairs throughout the state. They have assisted the Committee on Medical History in its statewide work. Every physician should be familiar with the work the Auxiliary has done and is doing in the nurse recruitment program. The Auxiliary published the "Auxiliary News" four times each year. The list is long and rather impressive.

When the members of the Auxiliary to the Illinois State Medical Society attend meetings of the A.M.A. Auxiliary at the same time their husbands attend regular sessions of the national society, we find a rather peculiar situation facing them. ILLINOIS IS THE 47th STATE IN PERCENTAGE OF MEMBERSHIP IN THE AUXILIARY.

Maryland is 48th with 23.48% of the wives affiliated with that Auxiliary. Illinois is 47th with 26.01%. Kansas has 91.38%, Pennsylvania has 45.62%, Ohio has 63.50%, Texas has 83.45%, California has 45.63%, and so it goes!

It would seem that the members of the Illinois State Medical Society could cooperate with the Auxiliary to see that new county society auxiliaries are organized. If there is some valid reason why the county society does not desire to organize an Auxiliary, individuals may join the Woman's Auxiliary to the Illinois State Medical Society as MEMBERS AT LARGE. The chairman for Members-at-large for the coming year is:—Mrs. Walter Shriner, 913 Williams Blvd. Springfield, Illinois.

If your county medical society desires to organize an Auxiliary, a letter to the President will

give you the information necessary to proceed. She will contact the Councilor for the Auxiliary in the District — and the wheels will turn. For information, you may write to: Mrs. A. T. Kwedar, President Woman's Auxiliary — I.S.M.S. 1123 South Grand Avenue West; Springfield, Illinois.

The Illinois State Medical Society the **FOURTH LARGEST SOCIETY IN THE UNITED STATES.** Our Auxiliary should not be asked to attend national meetings as the 47th state auxiliary.

The drive for MEMBERS AT LARGE in the Auxiliary should be one of the important activities for each county medical society where an Auxiliary is not organized. Dues are outlined in the Auxiliary Constitution and By-Laws for Members-at-large, as follows:

"A Member-at-Large shall pay annually to the State Auxiliary dues of three dollars (\$3.00), of which one dollar (\$1.00) shall go to the national Auxiliary, and one dollar (\$1.00) to the Benevolence Fund."

Before the next annual meeting of the National Auxiliary membership in the Woman's Auxiliary to the Illinois State Medical Society should increase materially.

### **DISEASES TRANSMITTED TO MAN FROM ANIMALS**

Zoonosis is any disease in man acquired from lower animals. According to WHO News, more than 80 diseases are in this category. Of these, 27 are transmitted to man by livestock (cows, oxen, pigs, horses, etc.); 26 by dogs; 14 by cats; and the remainder by different forms of wild life.

Authorities who are fighting disease on a global scale are directing their attention to bovine tuberculosis, leptospirosis, Q fever, brucellosis, and rabies. The latter is a serious problem in many parts of the world and control is achieved by concentrating on the main culprit — the dog. Campaigns include quarantine measures, elimination of strays, and vaccination of the dog population.

Bovine tuberculosis is responsible for 10 per cent of human tuberculosis in countries where there are no regulations against the consumption of raw milk. Leptospirosis is the scourge of rice growing areas and, like Q fever, is always a threat to butchers, veterinarians, and farmers.

## **CURRENT SOCIO-ECONOMIC PROBLEMS**

Many regard the social and economic problems that plague the medical profession today a natural evolution rather than part of the social revolution that is sweeping the modern world. The situation stems from the progress made in diagnosis, treatment, and prevention. We have made medical care so good, everyone wants it at a price he can afford.

We wish to believe this, but it is difficult in face of the increasing number of people who are ready to accept the "welfare state." There is a strong lobby in Washington advocating an extension of Veterans' medical care. Congress will be asked to decide whether the American taxpayer should finance the medical care of non-service connected illness. This is known popularly as the VA route to socialized medicine.

The defeated legislation on government subsidies in the field of private and voluntary health insurance (reinsurance) also was viewed with suspicion. The government proposal to pay up to 75 per cent of abnormal losses was aimed at protecting the insurance carrier but many believe it would encourage the carriers to take greater risks. In addition, with mismanagement, it was too easy to expand into a full scale national compulsory plan.

Private insurance and voluntary, nonprofit associations such as Blue Cross and Blue Shield have done a wonderful job but many believe these plans are not comprehensive enough and are easily abused. For this reason, deductible and catastrophic insurance plans are being studied by various organizations. Abuse is minimized when the insured individual pays something. A \$50 to \$100 deductible clause takes care of this. The individual pays minor medical bills but is protected against higher expenses. It is the latter that most of us worry about because no one wants to lose all his savings or end up in debt because of sickness or accident.

The State Medical Society of Wisconsin recently approved a plan for catastrophic illness insurance which provides 100 per cent coverage for professional services among participating physicians. Coverage up to \$5,000 per person and \$15,000 per family is allowed for one accident or illness. The deductible aspect enters the picture in payment for other services. They will

pay 80 per cent of the cost of the ambulance, laboratory, x-ray, and physical therapy. They also will provide 80 per cent of special nursing care, blood or plasma, drugs and medicine, appliances, and rental fees for equipment.

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## **REPORT ON THE DOCTOR DRAFT**

This article has been prepared to inform you of the recent changes in the processing of physicians for military service. It also includes statistics in processing the June 1954 graduates of the medical schools in Illinois.

As you know, this Committee reopens the cases of all physicians who are classified essential, recommending them available where possible in order that some of them who were previously essential could begin to fulfill their military obligation. We have done this because the National Advisory Committee requested that we very carefully review all physicians in priorities I and II of all ages, and priority III born after 30 August 1922.

The calls for special registrants under the Doctor Draft have increased. We believe this is due to the fact that a large number of professional people entered on active duty in 1952, and replacements must now be sought for them on their release from active duty after two years of service. There is not a large pool of doctors ready and available for service. The Advisory Committee has had to tighten its regulations with no recommendation of essentiality being given unless the individual can be clearly proven to be necessary to the maintenance of the National health, safety and interest.

The cases of all individuals in priorities I and II, who are still classified as essential, were reopened in April with the result that many have been recommended as available. After a careful review, the Committee found there are still eleven physicians essential to their local communities — five in priority I located in the communities of San Jose, Norris City, Fisher, Saybrook and Virginia, Illinois. There are six in priority II who are located at O'Fallon, Annawan, Galva, East St. Louis, Centralia and Havana, Illinois. There are still five physicians in the teaching profession who are not available. The cases of the physicians currently classified as essential to their local communities or the teaching field

will be reopened in October to determine where an available recommendation can be sent. In granting further essentiality careful consideration will be given to the effort made by the community or the dean of the school to secure a replacement.

Since 1 July 1954, this Committee has not declared any resident physician to be essential, due to the policy announced by the National Advisory Committee, nor will it request an essential classification for a resident unless the hospital can prove it cannot operate without his services. He literally must be the only resident in that field in that hospital, with no one to replace him.

The Armed Forces have estimated they may need approximately 4,000 physicians between 1 July 1954 and 30 June 1955. Illinois has already had a call for 31 in June, 17 in July and 73 in August. These are all physicians and have been allocated to the Navy on the first two calls, and on the third call to the Navy and Air Force. The Army is not commissioning physicians at this time, but is merely calling to active duty all

those liable who hold reserve commissions. In talking to the medical school students this past June, we requested them to fill out our Advisory Committee questionnaire. I think it worth while to point out to you the statistics compiled from the questionnaires sent in by the graduates on their liability for service. Listed below are the statistics.

The National Advisory Committee has requested that all doctors liable for service as both regular and special registrants be informed of the urgent need for filing applications for commissions and immediate active duty. This urgency for doctors liable for service to make early applications for commissions and immediate active duty is further stressed by recent changes in the processing of special and regular registrants. In order that you may fully understand these changes, I am quoting below Illinois Selective Service State Memorandum No. 16-3F, Subject: Postponement of Regular Registrants who are also Special Registrants. Since this is so well stated, I believe no further explanation is necessary by this Committee.

June 1954 Graduates of Illinois Medical Schools					
Priority Two Physicians	No. of Men	Amount of Creditable Military Service	Received		
Year of Birth					
1923	1	15 Months	ASTP Training		
1924	1	7 Months	V-12 Training		
Priority Three Physicians					
Year of Birth	Number				
1921	1				
1923	1				
1924	1				
1925	1				
1926	4				
1927	9				
1928	51				
1929	100				
1930	41				
1931	6				
TOTAL 215					
Priority Four Physicians					
	MONTHS OF MILITARY SERVICE				
Year of Birth	Under 6 Months	Over 6 months, less than 12	Over 12 months, less than 17	Over 17 months, less than 24	Over 24 months
1918					1
1920					1
1921					1
1922					1
1924				1	8
1925			3	3	13
1926			3	21	11
1927		5	13	21	2
1928	1		2	3	1
1929			1		
TOTAL	1	5	22	49	39
This makes a total of 117 Priority four graduates who filled out our Advisory Committee questionnaire					

This makes a total of 117 Priority four graduates who filled out our Advisory Committee questionnaire.

State Memorandum No. 16-3F

Subject: *Postponement of Regular Registrants Who Are Also Special Registrants*

1. The following State Memorandums are hereby rescinded: 16-3C, 16-3D, and 16-3E.

2. Operations Bulletin No. 88 has been revised as of 16 July 1954. Under the new provisions DD Forms No. 390 will not be forwarded to the registrant and the local board will not take part in the processing of the commission. The local board should advise the registrant that he will be processed for induction as a regular registrant without regard to his special registration status; however, he will have his induction postponed if, prior to his actual induction, he presents official proof that he has *applied for a commission and also for immediate active duty*.

3. The registrant must not only apply for a commission but he must also at the same time request immediate active duty to take effect as soon as the commission is issued. This immediate active duty must be requested at the time the application for commission is filed. Some of the Armed Forces officer procurement offices will notify the local board directly of the filing of the application and request for active duty. Other offices, including the Army, Navy, and Air Force Departments in Washington, may either notify the local board directly or only notify the registrant of the filing or receipt of these applications. In case only the registrant is notified, he should show the notice to the local board and the clerk should make a notation of the date and information for the Cover Sheet. Either of these methods of notification will be acceptable. The only requirements are that the notice must (1) be from the Army, Navy, or Air Force, (2) show the date of application, and (3) specify that immediate active duty is requested.

4. The registrant will be ordered to report for induction in his regular turn. If the above information is in the file when his induction order is mailed, the registrant's induction will immediately be postponed and the next available registrant will be placed on the induction call in his place. If the information is received after the induction order is mailed and any time up to the actual induction, the induction will be postponed. The postponement will be "until further notice," and the authority for the postponement is section 1632.2 (a) of the Regula-

tions. If time permits, another registrant will be substituted in the induction call.

5. If a registrant applies for a commission but there is no official evidence in the file that he has requested immediate active duty, he is *not* eligible for any postponement of induction under the provisions of this State Memorandum.

6. The local boards should mail their induction orders as soon as possible after receipt of a call from State Headquarters so as to give each registrant as much time as possible to process his commission. In order to further assist the registrant when he is placed in Class 1-A and the processing begins (for dentists and veterinarians after graduation, and for physicians after completion of internship) the local board should notify the registrant by letter as follows:

"You will be processed for induction as a regular registrant without regard to your status as a special registrant. Your induction as an enlisted man will be postponed if, prior to actual induction, your present official evidence to this local board that you have applied for a commission in the Army, Navy or Air Force *with a request for immediate active duty*. It is your responsibility to initiate this action and to keep your local board notified of all actions taken. You may contact this local board for further information including the addresses of the officer procurement offices of the Armed Forces."

7. In case one branch of service should refuse to accept the registrant's application he should immediately apply to another, since a reject application is not a basis for postponement. Registrants being processed under this State Memorandum need not be processed separately as special registrants. Regular registrants who are also special registrants and who have been found disqualified as regular registrants may be processed as special registrants in accordance with Clerical Instructions Nos. 170 and 177 (paragraph 1).

8. Registrants who have already applied for commissions under the previous provisions of Operations Bulletin No. 88 should be contacted to determine their current status. When their papers were forwarded, the Surgeon General of

the Army was to allocate them to some branch of the Armed Forces which would then contact the registrant and furnish him with the necessary application papers. Such a registrant *must not delay* in completing these papers and *also must request immediate active duty*. Should he delay in processing the application or not request active duty, his postponement will be terminated.

9. Applications for commissions may be made at any of the following officer procurement offices:

**ARMY:** Medical Officer Procurement Section, 5th Army Headquarters, 1660 East Hyde Park Blvd., Chicago 15, Illinois. *Or:* The Surgeon General, Department of the Army, Washington 25, D. C.

**AIR FORCE:** The Air Surgeon General, Department of the Air Force, Washington 25, D. C. (*All Air Force applications must go here*)

**NAVY:** Office of Naval Officer Procurement, 844 North Rush Street, Chicago, Illinois. *Or:* Office of Naval Officer Procurement, 12th and Market Streets, St. Louis 1, Mo. *Or:* The Surgeon General, Department of the Navy, Washington 25, D. C.

PAUL G. ARMSTRONG  
State Director

This Committee will continue to reopen the cases of all men still classified as essential, with the object of making every possible man available inasmuch as we do not want to have to call the older priority III physicians for service. We believe that as many as possible of those in priorities I and II should be called in order that they may fulfill their military obligations prior to calling the older priority III's.

Carl F. Steinhoff, M. D.  
Chairman  
Illinois Advisory Committee

## RETROLENTOL FIBROPLASIA—A CHALLENGE TO MEDICINE

Because of the marked increase in the incidence of retrolental fibroplasia which has become the most important single cause of blindness in pre-school children, our need for knowledge concerning its incidence, the social and medical problems it presents and information concerning other ocular problems possibly associated with prematurity has become paramount.

At the request of the Chicago Ophthalmological Society, the Illinois Society for the Prevention of Blindness has agreed to undertake a study of the problem. The State Department of Public Health, the Chicago Board of Health and the Chicago Pediatric Society have already agreed to participate and other key state groups are being invited.

Retrolental fibroplasia is a new ocular disease. The first cases of it were described in 1942. It occurs almost exclusively in infants whose birth weight is three pounds or under, born six to eight weeks prematurely. Almost everything about the disease is known, except what causes it and how to prevent it. Once fully developed, the tissue changes are irreparable. Intensive research and study about it is going on throughout the world. There appears to be a geographic variation in the incidence, which adds to the puzzle. In many cases, it results in total and hopeless blindness. It causes grave concern to obstetricians, pediatricians, and particularly ophthalmologists, constituting a most urgent and baffling challenge to medicine. The disease hits families of every economic, cultural and racial condition.

The co-operation, help and interest of all physicians in Illinois is urgently requested, particularly general practitioners, obstetricians, pediatricians, ophthalmologists, in supplying essential and pertinent information which may be requested.

# MEDICAL ECONOMICS

**The Medical Economics Committee. John R. Wolff, Chairman, Walter C. Bornemeier, Edward W. Cannady, Roland R. Cross, Jr., E. F. Dietrich, W. W. Fullerton, Edwin F. Hirsch, Frederic T. Jung, W. R. Malony, Caesar Portes, William Requarth, Frederick W. Slobo.**



## Health Agencies

Everyone is interested in good health and in preventing disease. We as physicians recognize our responsibility as the guardians of the nation's health. We also realize the natural emotional response of all individuals toward pleas of help to aid the unfortunate.

Our television sets are alive with drives to eradicate cancer, cerebral palsy, muscular dystrophy, leukemia, and heart disease. We are asked to buy Mother's Day seals, and tuberculosis seals. We contribute to the March of Dimes, the Red Cross, and other allied groups. We give our millions to these noble causes. Then we skeptical physicians wonder as to the accomplishments.

This skepticism is healthy because if we investigate rather than "gripe", we will find out that all these agencies are doing terrific jobs. Then if we too get in there and pitch, these groups will do even better.

If you doubt this—let's look at the record. What happened to the great white plague? The incidence of tuberculosis has certainly waned. Remember when the tuberculosis hospitals were overcrowded and had long waiting lists? Remember when this disease was always fatal by the time a diagnosis had been established.

Long ago, we knew that if you diagnosed

tuberculosis early, isolated the patient to prevent spread, and treated him in an appropriate fashion many would be cured and few would contract the disease. Yet we did not have enough hospital beds; we had few funds for research; and we had no public support for our ventures.

Finally, someone conceived the idea of raising money by selling tuberculosis seals at Christmas time. This was a great success—not only in raising funds—but in awakening everyone to the problem. Tuberculosis control committees were formed by medical societies, and citizens organized tuberculosis eradication committees. Governmental groups became interested—entire populations were surveyed for tuberculosis. Early diagnosis, hospitalization, and adequate therapy became the order of the day. Today we can see the results.

Yet we physicians continue to remain skeptical, confused, and afraid concerning many of these laymen sponsored ventures.

Let's study the development of one specific venture in Chicago, the Cancer Prevention Center, Incorporated, of Chicago.

We all know that one of the great secrets in the cure of cancer is early diagnosis. If we could examine all our patients, at least every six

months, we could detect lesions of the skin, oral cavities, breast, pelvis, and rectum in their earliest phase. In spite of the tremendous public interest in cancer, in fund raising, research, and hopes of finding cures, little had been done in response to our plea of just being able to examine healthy individuals at repeated intervals.

About twelve years ago, an alert physicians' wife in Chicago decided to do something about this. She converted a group of doctors to this cause and organized this cancer prevention center. It is still going strong and doing a wonderful job.

This cancer prevention center was organized with the idea of showing the layman what a physical examination is like, of lecturing to him about cancer, of communicating the findings at examination to the patient's doctor, and encouraging the patient to have his followup and repeat examinations by his own physician.

When this group first went to work, doctors in general were skeptical. The results obtained might not justify the time and energy involved. This seemed to be a form of socialized medicine. It would take patients away from the doctors' office. Laymen would be controlling medical care. It would set up a group of pretended super-specialists.

One of the members of this Medical Economics committee felt that way, so he decided to become a part of the Cancer Prevention Center just to see how they function. He was awakened to the goodness of this work and is now Medical Director of the Center. Leaders of medicine work along with the health conscious leaders of our community, to help the Center in their work.

Today the Cancer Prevention Center is accomplishing its purpose and in an ethical manner. Only healthy people are examined. History, complete physical examination, including sigmoidoscopic examination, chest x-ray and complete blood studies are performed on every patient.

Vaginal smears are studied in all females. When abnormalities are discovered the patients are called back to be seen by consultants. They return for a group meeting where the Director lectures to them on cancer, the purposes of the clinic, and the need of seeing their doctor who can do this examination himself. Each patient is advised to see his doctor, and where abnormalities are found, a letter is mailed to the patient's doctor. Each patient is given a card to present to his doctor, who can mail it to the Center to obtain the findings of the examination. No treatment is given at the Center. If a patient does not have a doctor, the patient is referred to one on the panel given to the Center, by the Chicago Medical Society.

The Cancer Prevention Center is self supporting from contributions and from a small fee charged for examination. The only doctors who do not give their services free are the ones who originally examine the patients. These young men are compensated in a small fashion.

The value of these examinations has been well proven. The statistical studies of patients seen, cancers detected, and other pathology noted have all been presented in our authoritative medical journals.

The purpose of this discussion of one small health agency is to demonstrate what can be accomplished when all the people interested in health work together.

We must recognize the idealism and purity of purpose of the public spirited citizens within these organizations. We must join with them; by so doing, we can direct their efforts toward attaining the goals in mind.

We must lead them in this method of attacking disease. We can do this easily by all of us working together in a voluntary way, can avoid governmental help and can proceed to improve America's health in the American way.

# THE P.R. PAGE



## Slogan

The Medical Society of New Jersey has adopted as its public relations slogan for 1954-55 this sound principle of all P.R. programs: "Public Relations for medicine means Personal Responsibility for You!"

## Coroner Reform

One personal responsibility every member of the Illinois State Medical Society can keep in mind over the next year is the need for reform of the system of investigating unexplained deaths. Currently this function is by statute the duty of the coroner of each county. For 30 years or so it has been recognized that the resources and advances of modern medicine have not been brought into play as they should be if the true cause of death is to be determined in every case. In only a minority of counties, in fact, is the coroner a physician and probably few even of these men have any training in the scientific disciplines involved, the medicolegal problems and in homicide investigation. The result is that many deaths are never adequately studied, undoubtedly some murders and suicides go unrecognized and innocent persons are unjustly accused.

An important by-product of this state of affairs is the observation that many of our statistics on causes of death, particularly heart disease, may logically be questioned. It is easier for

a coroner's physician to write "heart disease" and sign the death certificate, when there is nothing particularly suspicious about the case, than it is to make a proper examination and autopsy.

Moreover, without adequate study, many newly developed causes of death may go unrecognized. The exposure of the wide-spread illicit use of barbiturates or "goof-balls" came about through the scientific efficiency of the medical examiner's office in New York. The pathologist has many times uncovered new industrial hazards developing with new products and processes.

Against the precision and accuracy of good pathology, Illinois can offer only the obsolete coroner's jury of six "good and lawful men" chosen from the neighborhood, (usually the court house loafers) whose opinion as to cause of death would be worthless if they had one. The futility of the process is recognized in the law, which forbids the use of evidence and findings of a coroner's inquest in any future lawsuit.

Medicine has long realized the need for reform and in fact presented a bill designed to establish a medical examiner system to the last session of the General Assembly. It did not pass, but will undoubtedly be presented again next year. The opposition comes largely from politicians on both sides, who do not want to surrender the patronage and perquisites involved. Only determined public pressure can put the bill over.

The time, however, is especially propitious for a serious effort. Recently in Chicago a prolonged coroner's inquest again emphasized the ridiculous futility of the procedure and roused strong feelings among all who observed. The Chicago Daily News, for instance, assigned its science writer, Arthur J. Snider, to write a series of articles on the coroner system and the need for reform. The series was well done and presented sound evidence which will be valuable in persuading legislators next year.

Meanwhile every member can help by talking to his own legislators and organizing popular sentiment for reform.

### **Infiltration**

The recent hassle in Chicago between the American Medical Association and the American Legion over the Legion's demand for free medical care for all illnesses of veterans and their families again brought the issue into the open. The national commander accused medicine of opposing all medical care for veterans. This was a deliberate mis-statement, on which Dr. George F. Lull, American Medical Association general manager, called him immediately. The American

Medical Association has always accepted the principle of full medical care for service-connected disabilities and for tuberculosis and neuropsychiatric cases.

It is difficult to picture the Legion, which is so patriotic that it considers the Girl Scouts subversive, as setting up the strictly un-American doctrine that the veteran, by the fact of his service, is a "special class of citizen" and entitled to privileges, such as free medical care for life. That is, however, exactly what the Legion has maintained and still maintains. The "veteran" may have spent only a couple of months in the Army as a yardbird picking up papers around Camp Grant before his N.P. discharge came through, but, the Legion holds, he is a special citizen, whom the others must care for for life.

The flareup calls attention to the fact that many physician veterans, eligible for Legion membership, have not joined. More are members, but are not active.

If there were more aggressively active physician members in the Legion, it might be possible to inject a c. c. or two of sanity into Legion leaders and bring them back to sound social, economic and patriotic views.

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### **HOW TO WIN THE YOUNG PATIENT?**

I should like to present some simple suggestions that might serve to build new relationships between ourselves and the children we serve. If and when possible we might encourage parents to prepare children for their visit to the doctor, honestly and forth-rightly, free of alarm, and full of explanation and understanding. If we are to accommodate children in our offices, let us make provision for them with a playroom or a play area in the corner of the waiting room, adequately demarcated by a simple rail and con-

taning toys, books, crayons, paper, and other simple things to captivate the interests and divert the attention of children. If there are children in the family other than the one needing attention, encourage the mother to bring the others to the play area so that they may enjoy the visit to the doctor's office as an excursion into a new play experience, so that the doctor's office will connote fun instead of fright. Often a box of lollipops on the doctor's desk will help the child to relate to the doctor as a friend who understands. *Robert W. Foote, M.D., J. Tennessee M. A. March, 1954.*

# CORRESPONDENCE



## TREATMENT IN PSYCHIATRY LECTURES ANNOUNCED

The fifth annual North Shore Health Resort lecture series on "Treatment in Psychiatry II" has been announced by Samuel Liebman, M.D., medical director of the hospital.

All physicians are invited to attend without charge. A question and answer period follow each lecture which begins at 8:00 P.M. at the hospital, 225 Sheridan Road, Winnetka. The program follows:

Oct. 13, 1954—The Evaluation of the Patient's Emotional State by the General Practitioner, F. C. Redlich, M.D., Professor and Chairman, Department of Psychiatry, Yale University, School of Medicine.

Nov. 3, 1954—The Medical and Psychological Value of a Thorough Physical Examination, Stewart G. Wolf, Jr., M.D., Professor and Head of the Department of Medicine, Consultant Professor of Neurology and Psychiatry, and Supervisor of Clinical Activities of the Oklahoma Medical Research Foundation.

Dec. 1, 1954—The Physician's Responsibility to Patients Suffering from Emotional Disorders, Edwin F. Gilder, M.D., Professor of Psychiatry and Head, Department of Neuropsychiatry, Washington University School of Medicine; Psychiatrist-in-Chief, Barnes and Allied Hospitals; Section Head in Psychiatry, St. Louis City Hospitals.

Jan. 5, 1955—The Relationship Between the Physician, the Patient and His Family, Fritz Kant, M.D., Professor of Neuropsychiatry, University of Wisconsin Medical School.

Feb. 2, 1955—What and How to Tell the Patient and

His Relatives of the Patient's Serious Physical Disorder, D. Ewen Cameron, M.D., Director of the Allan Memorial Institute of Psychiatry; Professor of Psychiatry and Chairman of the Department, McGill University; Psychiatrist-in-Chief, Royal Victoria Hospital, Montreal, Canada.

Mar. 2, 1955—The Value of Listening, Understanding and Not Judging, Lawrence C. Kolb, M.D., Professor of Psychiatry, College of Physicians and Surgeons, Columbia University; Director, New York State Psychiatric Institute.

Apr. 6, 1955—The Value of Emotional Support and Environmental Manipulation, Raymond W. Waggoner, M.D., Professor and Chairman of the Department of Psychiatry, University of Michigan Medical School; Director of the Neuropsychiatric Institute of the University of Michigan.

Apr. 27, 1955—The Need for Limits to Permissiveness, Louis B. Shapiro, M.D., Staff Member, Institute for Psychoanalysis, Chicago.

June 1, 1955—The Effect of Psychiatric Treatment upon the Patient's Goals, Jacob E. Finesinger, M.D., Professor and Head, Department of Psychiatry, University of Maryland School of Medicine, Chief Psychiatrist, University Hospital, Baltimore.

## CLINICS FOR CRIPPLED CHILDREN LISTED FOR OCTOBER

Twenty-two clinics for Illinois' physically handicapped children have been scheduled for October by the University of Illinois Division of Services for Crippled Children. The Division will conduct 17 general clinics providing diagnostic orthopedic, pediatric, speech and hearing ex-

aminations along with medical social and nursing services. There will be 4 special clinics for children with rheumatic fever and 1 for cerebral palsied children.

Clinics are held by the Division in cooperation with local medical and health organizations, both public and private. Clinicians are selected among private physicians who are certified Board members. Any private physician may refer to or bring to a convenient clinic any child or children for whom he may want examination or may want to receive consultative services.

The October clinics are:

October 5 — Flora, Clay County Memorial Hospital

October 5 — Quincy, Blessing Hospital

October 6 — Hinsdale, Hinsdale Sanitarium

October 7 — Sterling, Field House

October 7 — Cario, Public Health Building

October 8 — Chicago Heights (Rheumatic Fever), St. James Hospital

October 12 — East St. Louis, Christian Welfare Hospital

October 12 — Peoria, St. Francis Children's Hospital

October 14 — Elmhurst (Rheumatic Fever), Memorial Hospital of DuPage County

October 14 — Litchfield, Sihler School

October 14 — Springfield, St. John's Hospital

October 19 — Danville, Lake View Hospital

October 20 — Alton, Alton Memorial Hospital

October 20 — Chicago Heights, St. James Hospital

October 21 — Rockford, St. Anthony's Hospital

October 22 — Chicago Heights (Rheumatic Fever), St. James Hospital

October 26 — Effingham (Rheumatic Fever), St. Anthony's Memorial Hospital

October 26 — Peoria, St. Francis Children's Hospital

October 27 — Elgin, Sherman Hospital

October 27 — Springfield (Cerebral Palsy), Memorial Hospital

October 28 — Bloomington, St. Joseph's Hospital

October 28 — Mt. Vernon, Masonic Temple

## A PLAN TO INCREASE COUNTY SOCIETY ATTENDANCE

Having observed for many years the usual poor average attendance at the meetings of the County Medical Societies throughout Illinois, has prompted me to write to you concerning this distressing condition and to try to offer a suggestion for improvement.

Many years ago the attendance was poor because of bad roads and lack of convenient ways to travel. The loss of time was an element. Good speakers were scarce.

Now this has been changed. Good instructive speakers are easy to obtain and the good roads and autos make it easy and pleasant to attend with very little loss of time.

However, with all these advantages many of the member physicians simply do not attend. They will attend the staff meetings of their hospitals because they think they must in order to preserve their standing and rights in the hospital with which they are affiliated.

But when it comes to attending the meetings of their own medical society so many take very little interest or make any effort to attend. In fact they try to find reasons and excuses for not attending. Some use it as an excuse to take the afternoon or evening off; to go fishing; attend a show, work at home and some I am sorry to say hope to profit by getting their fellow practitioners patients.

Now how can this be changed? Why do they not take more interest and pride in their own professional organization? Is there anyway this can be changed? The members of the labor organizations take great care and interest to attend their meetings.

It is never too hot, or cold or late for them to attend even if they do not like the officers or some of their fellow workers.

The writer of this is an active Rotarian and wishes to mention how they stress regular attendance. Reports are made monthly of the attendance of all the District Clubs in Southern Illinois.

It seems to me if some record was made of the percentage attendance at our medical meetings and this was published about quarterly by the State Secretary and sent to every County that it would help the attendance. Some prizes at the end of the year might be awarded the Society

having the largest percentage of attendance. The writer would like to hear from other secretaries on this subject. The fact remains what is the use of having meetings unless the members attend?

J. Q. Roane, M.D., Secretary  
Clinton County Medical Society  
Carlyle, Illinois

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### **AUXILIARY PRESIDENT'S MESSAGE**

As we begin another year of activity, I wish to extend the greetings of the Auxiliary to the members of the Illinois State Medical Society.

The position that we occupy as doctors' wives brings with it many responsibilities and never before has it been more necessary that we assume our obligation to our home, church and community.

"Leadership in the community in health service" is the theme chosen by our National President, Mrs. George Turner. If we are to assume this position of leadership, we must plan and develop a program of health education and service that will make us better citizens as well as better doctors' wives. The people of a community look to the doctor's wife for guidance and help in health problems.

Many fields of endeavor are open to us. There is a serious shortage of nurses in many communities throughout the country. We can help to interest girls in choosing the nursing profession by establishing Future Nurses' Clubs. We can provide scholarship and loan funds to aid them in securing the necessary education. We can work to make our community a safer place in which to live. The death toll due to traffic accidents is appalling. It is just as important to save a healthy life as a diseased one. Then there is the field of mental health and, of course, civil defense is still a 'must'. We can stimulate better health education by increasing our subscriptions to Today's Health. The auxiliary will continue to make generous contributions of the Benevolence Fund.

Grover Cleveland said, "A government for the people must depend for its success on the intelligence, the morality, the justice and the interest of the people themselves." We must work to GET OUT THE VOTE in the November election.

One of our projects this year will be to assist the Illinois State Medical Society with the promotion and sale of the "Medical History of Illinois."

Our accomplishments have been many and our growth has been steady throughout the years. By working together we can continue to build for the future.

Mrs. Albert Kwedar

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### **INSTITUTE ON RHEUMATIC FEVER**

La Rabida Sanitarium, Chicago, announces an annual institute on rheumatic fever on October 11-15th, 1954.

The institute will be educational in character and will cover the subject of rheumatic fever and rheumatic heart disease. It will be conducted for four days by members of the hospital staff, together with others selected from the medical schools in this city with which the hospital is affiliated, and by several invited guests. It will be directed primarily to the general practitioner or family physician and to nurses, medical social workers, occupational therapists, dentists and others with a similar interest in the subject. The fifth day, October 15th will be devoted to a scientific program concluding with the Robert A. Black lecture on rheumatic fever.

Advance registration will be required for those who wish to attend the entire five-day session. Attendance will be open to all these groups and will be limited only by the size of the building to accommodate those who attend. Visitors to individual sessions will be admitted by card on previous application.

Further information will be supplied by circular or application to INSTITUTE LA RABIDA SANITARIUM East 65th St. and South Shore Drive Chicago 49, Illinois.

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### **AMERICAN FRACTURE ASSOCIATION ANNUAL MEETING**

The annual meeting of the American Fracture Association will be held at the Shamrock Inn Hotel, Houston, Texas, October 11-14, 1954. This will be the 15th Annual Meeting of this Association which was founded in 1938.

An innovation this year will be the open discussion on Tuesday, Wednesday and Thursday, of any subject on the previous days program. Physicians intending to be present at this meeting are requested to bring their slides and case histories of interesting cases.

An interesting four day program has been

arranged to be of interest to physicians interested in any type of fracture work. On Monday, there will be round table luncheon discussions, each limited to 20 physicians, tickets to be issued at the registration desk.

For the complete program, write to H. W. Wellmerling, M.D., Secretary-General, the American Fracture Association, Bloomington, Illinois.

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## CHEST PHYSICIANS ELECT NEW OFFICERS

The American College of Chest Physicians registered 1150 physicians and guests at its 20th Annual Meeting held in San Francisco, California, June 17-20, 1954. This was the largest registration of any of the previous College meetings held on the west coast.

The following officers were elected for the year 1954-1955: President—William A. Hudson, Detroit, Michigan; President-Elect—James H. Stygall, Indianapolis, Indiana; First Vice-President—Herman J. Moersch, Rochester, Minnesota; Second Vice-President—Burgess L. Gordon, Philadelphia, Pennsylvania; Treasurer—Charles K. Petter, Waukegan, Illinois; Assistant Treasurer—Albert H. Andrews, Jr., Chicago, Illinois; Chairman, Board of Regents—Donald R. McKay, Buffalo, New York; Historian—Carl C. Aven, Atlanta, Georgia.

Dr. Otto L. Bettag of Chicago is Regent for the District and Dr. Darrel H. Trumpe of Springfield is Governor for the state of Illinois.

The 21st Annual Meeting of the College will be held in Atlantic City, New Jersey, June 2-5, 1955

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## FELLOWSHIPS IN PREVENTIVE MEDICINE TRAINING

To increase the number of well-trained teachers in the field of preventive medicine, the National Foundation for Infantile Paralysis is now offering a limited number of senior fellowships to physicians interested in study and research in the teaching of preventive medicine. This is a new effort to bring support to this field.

The program of study may be undertaken at an approved school of public health or in a department of preventive medicine of an approved medical school.

Fellowships will be awarded for one or more years, with stipends ranging from \$4,500 to \$7,

000 a year, depending upon marital status and number of dependents.

The fellowships will be awarded only to graduate physicians in good health who are United States citizens or applicants for citizenship, have completed at least one year of internship in an approved hospital and have had not less than two years of additional training and experience, including some teaching responsibility, in one of the specialties related to preventive medicine. Candidates are selected on a competitive basis by the Clinical Fellowship Committee of the National Foundation for Infantile Paralysis.

Each recipient of a fellowship must have the intention of teaching preventive medicine in the United States or its territories after completing his studies.

Fellowship applications are accepted any time during the year, but are activated only after Committee action. Applications received by September 1 are considered about November 1; those received by December 1 are considered about February 1; and those received by March 1 are considered on or about May 1.

For further information address the National Foundation for Infantile Paralysis, Division of Professional Education, 120 Broadway, New York 5, N. Y.

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## DERMATOLOGICAL PRIZE ESSAY CONTEST

The American Dermatological Association is again offering a series of prizes for the best essays submitted for original work, not previously published, relative to some fundamental aspect of dermatology or syphilology. Cash prizes will be awarded as follows: Five hundred dollars, three hundred dollars and two hundred dollars for first, second and third place, respectively.

Manuscripts typed in English with double spacing and ample margins as for publication, together with illustrations, charts, and tables, all of which must be in triplicate, are to be submitted *not later than November 15, 1954*. The manuscripts should be sent to Dr. J. Lamar Calaway, Secretary, American Dermatological Association, Duke Hospital, Durham, North Carolina. Those which are incomplete in any of the above respects will not be considered.

The results will be announced prior to January

1, 1955, and papers not winning a prize become the authors' property and will be returned promptly.

The candidate winning first prize may be invited to present his paper before the annual meeting of the Association with expenses paid in addition to the five hundred dollar prize. Further information regarding this essay contest may be obtained by writing to the Secretary.

## **CRIMINAL RESPONSIBILITY AND PSYCHIATRIC EXPERT TESTIMONY**

"Criminal Responsibility and Psychiatric Ex-

pert Testimony" is the most recent report issued by the Group for the Advancement of Psychiatry (GAP). It is a concise and instructive statement about some of the difficulties of certain procedural practices in the field of criminal responsibility and mental illness. The report makes specific recommendations aimed at removing barriers to realistic psychiatric testimony. This report has ethical implications for other health and welfare personnel, including doctors, psychologists, and social workers.

Copies of the report (25c) are available from GAP, 3617 West Sixth Avenue, Topeka, Kansas.

## **ORAL DIURETIC**

Xanthines and organic mercurials and combinations of these have been the subjects of our clinical investigations of diuretics during the past 20 years in Galveston. At first we were interested in getting more effective diuretics, but we emphasized the need for less toxic diuretics. Novasural, Salyrgan, and combinations with xanthines such as Mercupurin, Mercuphyllin, Mercuhydrin, and Esidrone were followed occasionally by fatal toxic effects on the heart muscle. A sulfhydryl (monothiol) group then was added and Thiomerin was first released to us. Thiomerin was found to be nontoxic, so nonirritating that it could be injected deep, subcutaneously, and able to produce a brisk diuresis. A host of organic mercurial diuretics were developed for easier administration subcutaneously, by rectum, and orally, but most of these have produced toxic or irritating side reactions and were inconstant in effect or unsatisfactory. Most of them have fallen into disuse, and many have been discarded.

We have always recognized that there has been a definite need for a safe and effective oral diuretic preparation. We were happy to have D. Dale Archer, M.D., and Rutledge Howard, M.D., of the Clinical Research Division of

Lederle Laboratories come to Galveston and submit to us their new physiologic, oral, nontoxic, active, nonmercurial diuretic, Diamox, for clinical investigations. Previous studies had established the fact that this carbonic anhydrase inhibitor offered a different and safer approach to the blocking of the reabsorption of sodium through the renal tubular epithelium than that accomplished by organic mercurials.

In a study of 34 hospitalized and 23 outclinic patients, the new oral, nonmercurial diuretic, Diamox, was found to produce profuse occasionally, but usually moderate diuresis after 500 mg. every eight hours for 3 doses and then 500 mg. daily. A daily reproducible diuresis for six to eight hours after the routine single daily dose of 500 mg. was produced. Diamox seemed to act physiologically.

We have found that Diamox usually is well tolerated, orally effective over relatively short periods of time, physiologically active, nonirritating, nontoxic, and with no significant side effects. On the other hand, the oral and rectal mercurial diuretics are and may be potentially dangerous, often irritating, and inconstant in action. *George R. Herrmann, M.D., et al. DIAMOX. Texas J. Med. April 1954.*

# NEWS OF THE STATE



## DEATHS

Mark P. Abrams, Chicago, who graduated at St. Louis College of Physicians and Surgeons in 1919, died July 20, aged 68. He was a member of the staffs of Alexian Brothers, American and North Chicago Hospitals.

John A. Bauer, Germantown, who graduated at Beaumont Hospital Medical College, St. Louis, in 1897, died July 15, aged 80. He joined the Clinton County Medical Society in 1899 and was a member of the "Fifty Year Club" of the Illinois State Medical Society.

Viola Bandy Beck, Oakland, who graduated at the College of Physicians and Surgeons of Chicago, School of Medicine of the University of Illinois, in 1903, died June 4, aged 79. She was a member of the Illinois State Medical Society.

James Eterno, Chicago, who graduated at Loyola University School of Medicine in 1916, died June 3, aged 59.

Bellenden Seymour Hutcheson, Cairo, who graduated at Northwestern University Medical School in 1906, died April 9, aged 70, of cancer of the pancreas. He was a member of the Illinois State Medical Society.

Edward Leroy Jackson, Maywood, who graduated at Rush Medical College in 1939, was found dead in River Forest, June 14, aged 46. He was a member of the Illinois State Medical Society and affiliated with West

Suburban Hospital in Oak Park and Illinois Research Hospital in Chicago.

William A. Knoop, Chesterfield, who graduated at Northwestern University Medical School in 1905, died July 6, in the Carlinville Area Hospital, aged 73. He was a member of the Illinois State Medical Society.




Thomas S. McCleery, Hazel Crest, who graduated at the Chicago Medical School in 1936, died July 26, aged 54. He was a member of the Illinois State Medical Society and of the medical staff of the Illinois Central Railroad.

Leslie Dutcher Smith, Chicago, who graduated at the College of Medicine and Surgery (Physio-Medical), Chicago, in 1904, died in the American Hospital, June 20, aged 77, of coronary thrombosis.

Oliver Isaiah Statler, Huntley, who graduated at Rush Medical College in 1906, died April 20, aged 74. He was a member of the Illinois State Medical Society and on the staffs of the Sherman and St. Joseph's Hospitals, Elgin.

Otto Francis Wellenreiter, Danville, who graduated at Georgetown University School of Medicine, Washington, D. C., in 1901, and was also a graduate in pharmacy, died June 14, aged 80. He was a member of the Illinois State Medical Society and on the staffs of St. Elizabeth and the Lake View Hospitals, Danville.

Nicholas Wolman, Chicago, who graduated at the Chicago College of Medicine and Surgery in 1911, died June 11, aged 78, of chronic myocarditis.

condition	 incidence of liver dysfunction	 incidence of blood lipid abnormalities	 suggested therapy
<b>obesity</b>	frequent +++	frequent ++	Methischol plus balanced low calorie diet.
<b>diabetes</b>	frequent ++++	frequent +++	Methischol as adjunct to diet. Insulin as necessary.
<b>atherosclerosis</b>	frequent +++	frequent ++++	Methischol and high protein, low fat diet.
<b>coronary disease</b>	frequent +++	frequent ++++	Methischol as adjunct to high protein, low fat diet and specific therapy.
<b>alcoholism</b>	frequent +++	frequent ++	Methischol plus high protein diet.

# methischol

**the complete  
lipotropic  
therapy**

... because it provides vitamin B<sub>12</sub> and liver fractions in addition to choline, methionine and inositol.

... helps normalize liver function, increase phospholipid turnover, reduce fatty deposits, and stimulate regeneration of new liver cells...

... helps reduce elevated cholesterol levels and chylomicron ratios towards the normal, and aids in achieving normal fat metabolism.

the suggested daily therapeutic dose of 9 capsules or 3 tablespoonfuls of Methischol provides:

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## BOOKS RECEIVED

The following books have been received for reviewing, and are herewith acknowledged. This listing should be considered as a sufficient return for the courtesy of the sender. Books that appear to be of unusual interest will be reviewed as space permits each month. Readers desiring additional information relative to books listed, may write the Editor who will gladly furnish same promptly.

**HANDBOOK FOR THE MEDICAL SECRETARY**—Third Edition. By Miriam Bredow, Dean of Women, Eastern School for Physicians' Aides, New York City. Gregg Publishing Division, McGraw Hill Book Company, Inc.

**ART AND PRINCIPLES OF ANESTHESIA**—A Practical Guide. By Phyllis A. Roberts, R.N., Anesthetist, Green County Hospital, Jefferson, Iowa, in collaboration with L. C. Nelson, M.D., Surgeon, Greene County Hospital, Jefferson, Iowa. Northland Press, Saint Paul, Minnesota, 1954.

**CONNECTIONS OF THE FRONTAL CORTEX OF THE MONKEY.** By Wendell J. S. Krieg, Professor of Anatomy, Northwestern University Medical School. Illustrated by the author. Charles C. Thomas, Publisher, Springfield, Illinois. \$10.50.

**ULTRASONIC AND ULTRASHORT WAVES IN MEDICINE.** By Johanna M. VanWent, M.D., Director Institute for Physician Medicine and Rheumatism, Amsterdam. Introduction by Kenneth Phillips, M.D., F.A.C.P., Director, Parkway Medical Clinic, and Dept. Physician Medicine, Jackson Memorial Hospital, Miami, Florida. Elsevier Publishing Company, Amsterdam, Houston, London, New York, 1954. \$9.00.

**LECTURES ON GENERAL PATHOLOGY.** Delivered at the Sir William Dunn School of Pathology, University of Oxford. Edited by Sir Howard Florey, Professor of Pathology. 733 illustrated. W. B. Saunders Company, Philadelphia, London, \$13.00.

**EMERGENCY TREATMENT AND MANAGEMENT.** By Thomas Flint Jr., M.D., Director, Division of Industrial Relations, Permanente Medical Group, Oakland and Richmond, Calif. Chief, Emergency Department Permanente Medical Group, Kaiser Foundation Hospital, Richmond, California. 303 pages. W. B. Saunders Company, Philadelphia and London, \$5.75.

**CANCER: Race and Geography.** Some etiological, environmental, ethnological, Epidemiological, and Statistical Aspects in Caucasoids, Mongoloids, Negroids, and Mexicans. By Paul E. Steiner, Ph.D., M.D., Professor of Pathology, The University of Chicago, Chicago, Illinois. The Williams & Wilkins Company, Baltimore, 1954. \$5.00.

**HEART: A Physiologic and Clinical Study of Cardiovascular Diseases.** By Aldo A. Luisada, M.D., Associate Professor of Medicine and Director, Division of Cardiology of The Chicago Medical School, under a Teaching Grant of the National Heart Institute, U. S. Public Health Service. With a foreword by

(Continued on page 58)

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## BOOKS RECEIVED (Continued)

- Herrman L. Blumgart. Second Edition. The Williams & Wilkins Company, Baltimore, 1954. \$15.00.
- PLANNING FLORIDA'S HEALTH LEADERSHIP. Volume 1; Medical Center Study Series. Edited by Louis J. Maloof. University of Florida Press, Gainesville, Florida. \$1.50.
- MEDICINE FOR NURSES. By W. Gordon Sears, M.D., (London) M.R.C.P. (London) Physician superintendent, Mile End Hospital, London, Examiner to the General Nursing Council for England and Wales. Sixth Edition. Edward Arnold Publishers LTD, London. \$4.00.
- LECTURES ON THE SCIENTIFIC BASIS OF MEDICINE. Volume 11, 1952-1953. University of London, The Athlone Press, 1954. Distributed in U. S. A. by John de Graff, Inc., 64 W. 23rd Street, N. Y. 10, N. Y. \$6.00.
- LET'S EAT RIGHT TO KEEP FIT — A practical guide to nutrition designed to help you achieve good health through proper diet. By Adelle Davis, A.B., M.S., consulting nutritionist. Harcourt, Brace and Company, New York. \$3.00.
- THE DOCTOR WRITES — an anthology of the unusual in current medical literature. Edited by S. O. Waife, M.D., F.A.C.P., Grune & Stratton, New York, 1954. \$3.75.
- WHY WE BECAME DOCTORS. Edited by Noah D. Fabricant, M.D., Grune & Stratton, Inc., 381 Fourth Avenue, New York 16, New York. \$3.75.
- THE PERMANENT REVOLUTION IN SCIENCE. By Richard L. Schanck, Chairman, Department of Sociology, Bethany College Lecturer, Carnegie Institute of Technology. Philosophical Library, New York. \$3.00.
- ISOTOPIC TRACERS — a theoretical and practical manual for biological students and research workers. By G. E. Francis, Reader in biochemistry, St. Bartholomew's Hospital Medical College, W. Mulligan, senior lecturer in biochemistry, Glasgow University Veterinary School and A. Wormall, professor of biochemistry, St. Bartholomew's Hospital Medical College — with a foreword by G. Hevesy. The Athlone Press, University of London, 1954. \$7.00.

The present trend toward providing treatment and supervision in the home for a relatively longer period of the tuberculosis patient's illness is creating some important problems. It makes close coordination among all professional personnel involved—physicians, nurses, social workers, rehabilitation workers, and others—even more important than before. James E. Perkins, M.D., NTA Bulletin, May, 1954.

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reach the point of becoming bad enough to justify a spinogram or intensive follow-up. I feel that in many of these cases there is progressive disk degeneration which perhaps represents the early phase in the large number of adult patients whose X-rays show long standing disk degeneration. A high percentage of these back complaints in teenagers respond well to symptomatic treatment, including well fitting, wide lumbosacral belts. Certainly this age group, as well as adults, should have a long period of conservative management before laminectomy is considered. All of our patients who eventually require laminectomy were first given an extended period of initial bed rest, heat, sedation, and support. If, after the period of rest and conservative treatment there has been no improvement or insufficient improvement to allow return to activity, further work-up is necessary. We feel that a spinogram is indicated in all these patients to more accurately localize the lesion and eliminate the possibility of an unrecognized double disk. *D. R. Lannin, M.D., Intervertebral Disk Lesions in the Teenage Group. Minnesota Med., Feb. 1954.*

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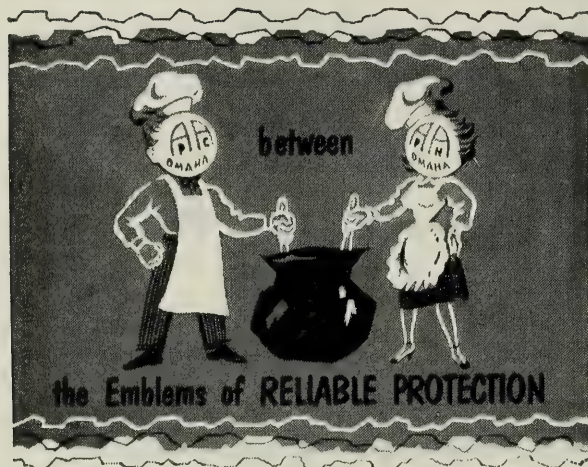
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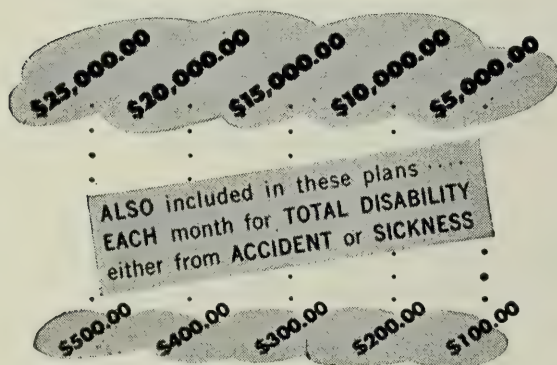
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## GOVERNMENT MEDICINE

Despite the emphasis on private medicine, there already is a great deal of government medicine in the United States, provided both by the federal government and by the governments of the individual states which constitute the federal union. For our present purpose, the federal is the more significant. It is chiefly the threat of the extension of the federal medical establishment which has provoked the vigorous and, in my opinion, rather blind reaction of organized medicine. The chief difference between government medicine in Great Britain and in the United States is that in the former, medicine is socialized in the true meaning of the term: it is owned, supported, integrated, and operated by government; under a single Ministry of Health, and is available to and for the benefit of all people whereas in the latter it is not integrated, there is no single ministerial control, and the services are provided only for certain special categories of citizens. The huge medical empire of the Veterans Administration is unique. Potentially affecting some 21 million veterans, it operates today 151 hospitals containing 119,400 authorized beds, which is eight per cent of all the hospitals in the United States. It offers free care in hospitals to all veterans for service-connected illness and, when facilities are available, for nonservice-connected illness also. The growth potential of the Veterans Administration's hospital system is thus unlimited. If the hospitals are not filled with service-connected cases, they fill up with nonservice-connected. Then, being full, if more beds are needed for service-connected cases, more hospitals are built. As veterans become ever more numerous, there is danger that private and voluntary medicine may become completely encircled by the free (tax supported) medicine of the Veterans Administration. This is a far greater threat to the medical status quo and its voluntary institutions than is compulsory health insurance; but so obsessed is the American Medical Association leadership with the desire to kill the latter, that it has on the whole ignored the former. Indeed, some of the doctors who are fighting what they call "socialized medicine" are serving in the Veterans Hospitals on salary with the greatest equanimity. Yet if there is anything in the United States that amounts to

(Continued on page 74)

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1. Friend, D.G., and Cummins, J.F.: J.A.M.A. 153:480 (Oct. 3) 1953.

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## GOVERNMENT MEDICINE (Cont.)

socialized medicine, the Veterans Administration's medical services are it. Should they engulf most of the rest of medicine, the United States would end up with a situation not unlike Britain's but it would have got there by default, not purposefully as has Britain. *J. H. Means, M.D., Medicine And The State. Practitioner, Jan. 1953.*

## GREGORY'S TREATMENT OF CANCER

The treatment of cancer by John E. Gregory, M.D., is based on his claim that all human cancer is associated with the presence of a single virus, a possibility that no other scientist or institution has been able to establish. Assuming thus that human cancer is an infectious process, and identical with a few forms of animal cancer known to be of viral origin, Dr. Gregory claims to have developed a vaccine and more recently to have discovered an antibiotic (Gregomycin) effective in the treatment of human cancer. The evidence accumulated by the Cancer Commission of the California Medical Association lends no support to these claims, either as to the role of a viral agent in the production of human cancer or as to any established value for Dr. Gregory's methods of treatment. In January, 1953, Dr. Gregory informed representatives of the Commission that he had treated about 100 cases of cancer and that "20 per cent have cleared up." Several months later the Commission had found a total of 82 death certificates from three cities, signed by Dr. Gregory or his assistants, on which the cause of death was stated as cancer. With one possible exception, probably due to natural remission, members of the Commission could find no objective clinical or pathologic evidence of real control of cancer by the Gregory method of treatment alone. In common with other noncurative agents, notable subjective improvement is apparent in some patients. Laboratory tests by qualified consultants indicate that Gregomycin has no antibiotic or antiviral activity, and that it fails completely to control certain animal neoplasms and types of leukemia which respond readily to chemotherapeutic agents of some established value. *Notices & Reports, The Treatment of Cancer by John E. Gregory, M.D., California Med. April 1954.*

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had the slightest headache now manage to make it to work every day of the year," says Kenneth Adams, company administrative director. "We feel that the extra expense has been more than compensated for by reducing unexpected absenteeism. *News, Comment, Opinion. Indust. Med.* May 1954.

## HIDDEN EMOTIONAL ORIGINS

The physician should constantly ask himself speculative questions as to the hidden source of anxiety, the defensive purposes, and the underlying desperate psychological needs which enter into preoccupation with health. Although this may not help much in a reliable solution of the psychopathology, such a dynamically oriented approach can help dissipate the frustration and helplessness of the physician. It is eminently more constructive in so far as the patient is concerned. Also, when the physician has some recognition of the hidden emotional origins of hypochondriacal symptoms, it is hardly possible for him to retain much prejudice. *Henry P. Laughlin, M.D., Overconcern With Health. M. Ann. District of Columbia, March 1954.*

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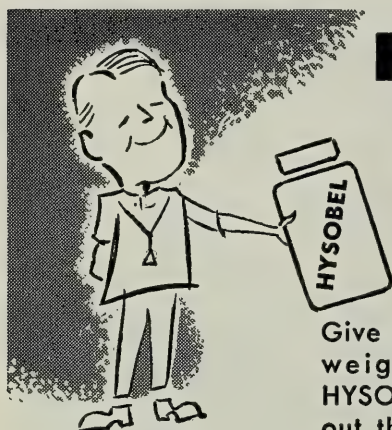
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## EXERCISE FOR PARKINSON'S DISEASE

Because of its slow progression, Parkinson's syndrome usually is more of a problem in the older age group. Occasionally it begins in old age, probably in association with degenerative disease of the central nervous system. As the disease is unrelentingly progressive in character, results of physical therapy are decidedly limited. On the other hand, omission of certain measures may lead to greater disability than is necessary. Certain types of exercises can be considered to be of some preventive value in lessening the degree of motor disability of these unfortunate patients. We have found passive stretching exercises for flexion contractures of the trunk and the extremities to be of some value if performed systematically and regularly. These may be combined with some active strengthening exercises of the extensor muscle groups, always keeping within limits of fatigue. We know, however, that power developing exercises alone will not prevent the

characteristic deformities. Special attention should be taken to maintain maximum chest expansion through breathing exercises and stretching of pectoral muscles. This type of exercise may be combined with relaxation technics to help reduce rigidity and, in many cases, tremor. *Arthur L. Watkins, M.D., Geriatrics, May 1954.*

Perhaps the most vital contribution made by the good tuberculosis sanatorium today, and not always clearly recognized, is the education of the patient. The patient who is put to bed in a sanatorium is first given encouragement and hope; in addition, he is taught respect for a relapsing and contagious disease, a respect made necessary by the undue optimism generated, in particular, by the lay press. Day after day physician and nurse will be able to impress him, individually and in groups, with the necessity of acquiescing to his disease, at least temporarily, and in appropriate cases, of managing his later life in accordance with his condition. *Roger S. Mitchell, M.D., J.A.M.A., March 20, 1954.*



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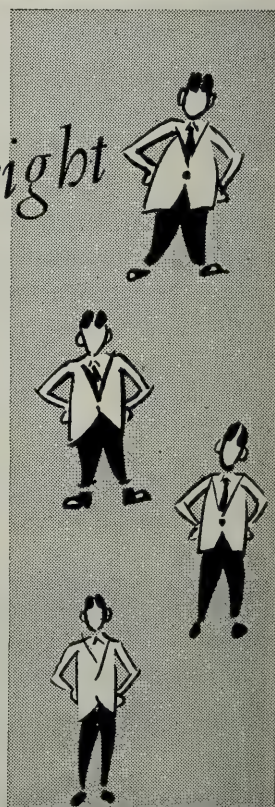
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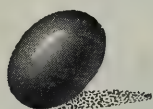


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*P. J. Sonnek, M.D. Congestive Heart Failure in the Elderly. Geriatrics, Feb. 1954.*

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1. McHardy and Browne: *Sou. Med. J.* 45:1139, 1952. 2. Lorber  
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Official Journal of the Illinois State Medical Society

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Vol. 106, No. 4

October, 1954

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## Anatomic Dangers in Gallbladder Surgery

Manuel E. Lichtenstein, M.D.  
Chicago

The anatomic dangers in gallbladder surgery have been reported by many workers in this field for many years and they are well described and illustrated in most text books and current medical journals. However, the dangers are not always appreciated well enough, accidents continue to occur and it is necessary to reemphasize the points in anatomy that are concerned with the ultimate recovery and well being of the patient following cholecystectomy.

An injury to the common duct even when it is recognized immediately and corrective measures are instituted promptly may be followed by stricture, cholangitis, biliary cirrhosis, prolonged disability and death of the patient. When unrecognized, the disability may be even greater, corrective measures become more difficult to carry out and damage to the liver is progressive and ultimately fatal. Thus, the prevention of injuries and the avoidance of accidents must be kept in mind constantly.

A common anatomic danger in gallbladder surgery is the abdominal wall incision. The danger lies in the possibility of post operative herniation due either to faulty healing from one or several of a variety of causes or malocclusion of the layers of the abdominal wall when closure of the wall is done. While the causes of faulty healing are well known and can be guarded against by proper nourishment, prevention of

infection and avoidance of distracting forces on the suture line, the anatomic factor of complete and accurate closure of the posterior sheath of the rectus muscle with its transversus muscle, transversalis fascia and the attached peritoneum needs constant reemphasis. Failure to suture this important layer due to negligence or inability to do so because of inadequate abdominal wall relaxation is the most common cause for post-operative herniation. Attention to the details of closure is well worth whatever additional time it takes to make a "blow out" proof closure. Suture materials should hold the tissues in approximation until healing is well established.

A second anatomic danger related to the abdominal wall incision is its size and the degree of exposure it affords. The incision should be large enough to permit exploration of the abdominal viscera, visualization of the field concerned in the operation and make possible removal of the gallbladder, probing of the ducts when necessary and control of bleeding that may be due to accident, disease or design. Frequently injuries to the ducts and blood vessels are due to inadequate or faulty exposure but many patients fail to make complete recoveries with relief from symptoms because of inadequate exploration. Pathologic processes responsible for symptoms could be seen or palpated on exploration but usually they are not sought for because of the inadequate exposure. Hiatus hernia, gastric or duodenal ulcer, benign or malignant tumors and inflammatory processes of the gastro-intestinal tract are overlooked and are responsible for the continuation of symptoms. Whether the surgeon

---

Professor of Surgery, Cook County Graduate School of Medicine; Associate Professor of Surgery, Northwestern University Medical School.

Presented before the Section on Surgery, 113th Annual Meeting, Illinois State Medical Society, Chicago, May 20, 1953.

prefers the oblique, transverse or longitudinal incision is not as important as the size of the incision. It must be large enough to afford good exposure. When coupled with a good light and gentle, careful retraction by an assistant who is conscious of his responsibility not to injure the tissues; adequate exposure will serve to prevent most of the accidents that actually occur in this field.

Accidents involving blood vessels and ducts may be immediately fatal, or result in prolonged disability before recovery takes place. In some patients recurring disabling episodes ultimately result in such changes in the liver that complete recovery is impossible and life is thereby shortened. Ligation of the hepatic artery distal to the gastro-duodenal may result in such extensive necrosis that the degree of liver damage is incompatible with life. This should call attention to the need for a satisfactory exposure of the neck and cystic duct of the gallbladder in order that large pulsating vessels may be seen, palpated and remain undisturbed. No matter how many cystic arteries may be present, any or all of them should be ligated where they are seen to enter the gallbladder. The closer to the gallbladder vessels are ligated the lesser the likelihood the hepatic vessels will be ligated or injured. There is no fixed position for all cystic arteries. They are ligated best when they are visualized as they enter the gallbladder. Here the admonition "take a good look" is more in order than clamping in the dark with a prayer and a hope that nothing but the cystic artery was caught by the clamp.

During surgery traction on the neck of the gallbladder causes the cystic artery or arteries to become taut and unless care is taken the vessel may be torn or mistaken for a fibrous band and cut with resulting hemorrhage.

The sites of origin of the cystic artery or arteries are from any branch of the coeliac axis of the aorta, the superior mesenteric artery or the aorta itself. While most commonly the cystic artery comes from the right hepatic artery, its origin from a large vessel at some distance from the gallbladder may subject it to injury during the act of retraction of the viscera adjacent to the gallbladder. This further emphasizes the need for care in the initial phase of cholecystectomy when the viscera are exposed and the field opened to view.

There are variations in the relative positions of the cystic duct and the cystic artery. While it has been emphasized that the vessels to the gallbladder are always on the medial size of the cystic duct experience shows that this is not always the case for the vessel or vessels may be lateral to the duct. Again I wish to emphasize the need for looking at the well exposed viscera and in a well illuminated field before any structure is cut.

There is danger when a vessel is cut or torn and retracts out of the field. The accumulation of blood obscures the ducts and makes possible the accidental injury to these structures in an effort to control bleeding. The insertion of the left index finger into the foramen of Winslow makes possible compression of the hepatic artery with the left thumb. This helps to control bleeding and permits the irrigation of the field with saline solution. "Drying" of the field by suction reveals the extent of injury. It is now possible to locate the bleeding point and thus avoid injury to the ducts.

There are marked variations in the length of the cystic duct. The extremely short ones are less than a centimeter in length and favor injury to the hepatic or common ducts. Others are as long as the gallbladder itself. Frequently a long cystic duct and the hepatic duct may lie side by side for one, several or many centimeters before they unite to form a common duct.

There are folds and kinks that are found in the cystic duct. The small leaf like projections into its lumen are the "valves of Heister". They are an embryological formation usually not found in the distal end of long cystic ducts. The cystic duct has usually the narrowest calibre of all the extra hepatic ducts and its surface is "corrugated" or irregular due to the spiral valve within its lumen. This is a useful point in anatomy for it helps to identify the cystic duct on sight.

*The location of the hepatic duct is constant. It lies at the bottom of the quadrate lobe of the liver.*

This lobe is bounded by the gallbladder or gallbladder fossa on the right, the round ligament on the left, the anterior margin of the liver superiorly and the hilus where the larger vessels enter and the hepatic ducts leave the liver. If this anatomic fact were more generally known

serious injuries to the hepatic duct could be avoided. The duct lies behind a layer of peritoneum and the latter must be opened to expose the duct. The thickness of this peritoneal layer varies with the degree of chronic peritonitis associated with the biliary tract disease.

The possibility of injury to an aberrant duct without knowledge that it has been torn or evulsed is present in every case. Some of these are very narrow in calibre and may be injured during cholecystectomy. Subsequently a large amount of bile may accumulate in one or several of the subphrenic or subhepatic spaces. Additional surgery now is a necessity and adds to the disability. The judicious insertion of a "drain" down to the bottom of the right subhepatic space (Morrison's pouch) and its exit thru a stab wound below the liver and right costal margin will help to evacuate bile that may accumulate in this most frequently involved space.

When there is oozing of blood or a bile stain is noted on a "sponge" or pad applied to the site of cholecystectomy I am certain it is better to use a "drain" and risk a useless application with a good result than omit the "drain" and risk subphrenic accumulation of bile.

#### SUMMARY

Anatomic dangers in gallbladder surgery are present from the moment the initial incision is made until the last suture is placed. Location

and size of the incision are factors that determine the ease with which surgery on the biliary passages may be accomplished. The importance of exploration to determine the presence of coincidental pathology is emphasized. In a well exposed and illuminated field all structures may be visualized and the risk of injury to vessels and ducts is minimized. The anatomic importance of the quadrate lobe is emphasized.

There is no substitute for care and skill. It is better to do well what needs to be done than to hurry the procedure and risk an accident. Time is not a factor as long as it is not wasted. Closure of the abdominal wall securely to prevent herniation is an essential part of the operation.

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#### DISCUSSION

Dr. Williams, Chicago: What is your favorite incision in cholecystectomy?

Dr. J. C. Thomas Rogers, Urbana: Do you vary your incisions, that is, does the habitus condition your method of attack?

Dr. Manuel E. Lichtenstein, Chicago: The incision should be made with a view of adequate exposure. In short, squat or obese individuals an oblique or transverse incision will expose more of a field than a longitudinal incision. When the patient is tall and has a "long" abdomen, the longitudinal incision is better. The important point is that you do not follow the book, you adjust your work to the particular patient. Every incision I make is custom tailored, to fit the patient.

---

## THE DOCTOR BUSINESS

Learning how to handle patients is one of the primary requisites of an adequate physician. A physician is not a salesman but, like a salesman, he must understand and be capable in his handling of people. This is often a rather upsetting idea and often a threatening one to the young scientist just going into practice. He is eager to have the world beat a path to his door, begging for the accurate scientific help he has been trained to give. Often he has come to scorn the methods of the older practitioner with his bedside manner. He vows his practice will include

no misspent time with what he calls "neurotics," healthy or otherwise. If he is in a specialty which is in great demand, or in an area without competition, he may complacently and profitably go along ignoring his patients as humans, but should he be competing against others who have a more mature and helpful understanding of people, he will soon either learn, starve, or leave. Knowing how to handle people is not only an essential of good medicine, it is often an economic necessity. *Franklin G. Ebaugh, M.D., Psychological Essentials of General Practice. South Dakota J. Med. & Pharm., April 1954.*

# The Management of Pain

Daniel C. Moore, M.D.  
Seattle, Washington

The management of all types of pain, i.e., pain of peripheral origin, pain of central origin, and psychogenic pain is a broad subject. It embraces not only establishing the type of pain, arrived at only after taking a careful history, doing a physical examination, and securing appropriate roentgenographic studies and laboratory work; but also its treatment which includes the use of antibiotics, salicylates, opiates, nerve blocking and surgery, i.e., cordotomy, lobotomy, sympathectomy, root section and nerve crush. To discuss the entire management of pain is a momentous task, attested to by the numerous textbooks on this subject, and not to be undertaken herein.<sup>1-9</sup>

It will be the sole purpose of this paper to call attention to some of the everyday curable diseases in which pain is often the outstanding symptom and in which nerve blocks may act as definitive treatment, i.e., immediately relieve the pain and shorten the duration of the disease. By doing these two things it automatically helps to reduce the cost of medical care, a goal of every physician in these days of rising costs and public resentment to the cost of medicine. The diseases included herein are those which my associates and I have had the opportunity to treat in our pain clinic.

## IMPORTANT FACTORS TO BE CONSIDERED PRIOR TO NERVE BLOCK

Before enumerating the diseases for which nerve blocks may be definitive treatment as well as the types of block to be used, a number of factors pertaining to the general use of regional block in these problems must be briefly summarized.

*Correct Diagnosis:*—A correct diagnosis must be definitely established prior to blocking. Otherwise, the promiscuous use of blocks in conditions which do not respond to this type of therapy will automatically cause therapeutic blocking to fall into disrepute.

---

Director, Department of Anesthesiology, Mason Clinic, 1115 Terry Ave., Seattle 1, Wash.

Presented at the Annual Meeting, Illinois State Med. Soc., Chicago, May, 1954.

*Selection of Block to be Used, i.e., Sympathetic or Somatic:*—The type of regional block to be used depends on the accuracy of the diagnosis. In most instances it is possible to accurately determine whether the sympathetic nerves or the somatic are involved. However, in a number of cases the disease involves both the somatic and sympathetic nerves and blocks of each will relieve the pain when either individually has little or no effect.

Sympathetic pain is usually characterized by hyperalgesia.<sup>8</sup> In this type of pain innocuous stimuli cause explosive sensations of pain and this results in a withdrawal reflex. The pain is "burning" in nature. There may or may not be other signs of dysfunction of the sympathetic nervous system, i.e., cyanosis, sweating and coldness of the part involved. *This type of pain is not necessarily associated with any specific nerve distribution.*

On the other hand, somatic and muscular pains are the usual types of painful impulses experienced following trauma or disease. This pain may be dull and aching or sharp and stabbing. It may be constant or intermittent. *It is in most instances limited to the distribution of the nerve or nerves of the dermatome or dermatomes involved.*

*When Should Block Therapy be Instituted?*—Patients who have diseases in which nerve block therapy is definitive treatment should be blocked immediately. It is unfortunate that frequently these patients are not referred for blocks until all other types of medical therapy have been exhausted and two or three weeks' time has passed.

*The Evaluation of the Effectiveness of Block Therapy:*—The ineffectiveness of the first block should never be a signal to discontinue further blocking procedures if the blocks have a physiological rationale. While in some cases a single block may cause the process to subside with re-establishment of normal physiological status, in most cases it is necessary to do a series of blocks. This fact should be adequately explained to the patient so that he does not become dis-

couraged if permanent relief is not obtained following the first few blocks.

**Establishment of a Satisfactory Block:**—Adequacy of sympathetic blocks should be evaluated by skin temperature tests, skin resistance tests or sweat tests of the area supplied by the sympathetic nervous system thought to be blocked. Peripheral somatic blocks must be judged on the basis of the area of analgesia produced and relief of the patient's pain.

**Selection of Drug to be Used:**—Drugs which cause tissue damage, particularly the neurolytic drugs, i.e., alcohol, phenol and Elocaine, have no place in treating pain associated with curable diseases.<sup>10,11,12,13</sup> They should be reserved to treat intractable pain problems resulting from incurable carcinoma, etc., and even in these problems, surgery if at all feasible is preferable. With physician-anesthesia available, it is only the patient of very poor physical status who cannot tolerate surgery.

**Use of Regional Block in Conjunction with Anticoagulant Therapy:**—If anticoagulant therapy is to be used as it often is during vascular problems, repeated blocks should be given only if there is a definite understanding or acceptance of the risk that hemorrhage may make it necessary to immediately reverse the effects of the anticoagulant therapy. This may be done by giving whole blood or protamine or both if heparin is being used and large doses of vitamin K, whole blood or both if Dicumarol is being used.

**Nerve Block vs. Sympatholytic Drugs:**—Nerve Blocks or surgery or both are usually preferable to the use of sympatholytic drugs, i.e., Priscoline, etc., and intravenous procaine when the sympathetic nervous system is involved. In elderly patients the sympatholytic drugs are to be avoided because they produce a generalized sympathetic block rather than a selective one and thereby occasionally result in a precipitous fall of the blood pressure.

**Why Nerve Blocks are Effective:**—Stimuli from infection, trauma, etc. tend to establish a pain pattern which once established may perpetuate itself and even grow worse. This is known as the "vicious cycle" (See Figure 1). If one of the links in the vicious cycle is broken, often the cycle regresses or stops. For example, the significant factor in sympathetic pain of vascular

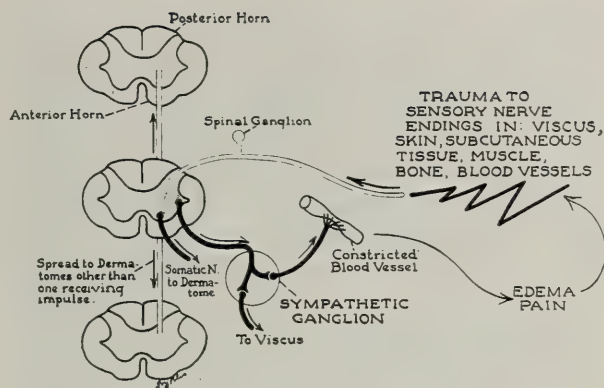


Figure 1

origin is reflex vasospasm of the collateral circulation. This in itself results in tissue hypoxia which causes a shift in the normal fluid balance of the extremity, resulting in edema and pain. Thus a vicious cycle is established which is self-perpetuating if one of the steps in the chain of events is not interrupted. Nerve blocks, usually of appropriate portions of the sympathetic nervous system, relieve the vasospasm breaking one of the links in the vicious cycle.

## PROBLEMS IN WHICH NERVE BLOCKING MAY ACT AS DEFINITIVE TREATMENT IN ADDITION TO RELIEVING PAIN

The pain problems of some of the common curable diseases and the blocks which are useful in terminating the pain are as follows:

- |                                                |                                                                   |
|------------------------------------------------|-------------------------------------------------------------------|
| I. Fractured Ribs                              | } Block of Somatic Nerves                                         |
| II. Musculoskeletal Pain                       |                                                                   |
| III. Occipital Headache                        |                                                                   |
| IV. Atypical Sciatica                          |                                                                   |
| V. Acute Thrombophlebitis                      | } Block of Sympathetic Nervous System                             |
| VI. Acute Vasospasm Following Venipuncture     |                                                                   |
| VII. Postoperative Radical Mastectomy Syndrome |                                                                   |
| VIII. Acute Pancreatitis                       |                                                                   |
| IX. Reflex Sympathetic Dystrophy               |                                                                   |
| X. Acute Herpes Zoster                         | } Block of Sympathetic Nervous System plus Block of Somatic Nerve |
| XI. Acute Chronic Bursitis                     |                                                                   |

**Fractured Ribs: Pathogenesis of Pain:**—The fracture, per se, irritates the intercostal nerve causing spasm of the intercostal muscle and pain. Once spasm of the intercostal muscle occurs, it may persist and actually prolong or intensify the pain.

*Treatment*:—Block of the intercostal nerve (s) of the broken rib or ribs will stop the pain and relieve the associated spasm of the intercostal muscles at least for the physiological duration of the drug used. This permits deep breathing, re-expansion of a collapsed lung and coughing. In addition, when the block is dissipated the pain is often less severe, and although muscle spasm may recur, it is often less pronounced. The intercostal block may be repeated as often as necessary. We have found that if the patient is blocked two to four times the pain is relieved sufficiently to preclude further block therapy.

*Musculoskeletal Pain: Pathogenesis of Pain*:—This type of pain may develop following direct trauma to a muscle or group of muscles, occupational strain, i.e. typewriting, sitting in one position, etc., or it may be idiopathic. Nevertheless, the muscles in the affected area are in spasm and, as can be determined by direct palpation, they often remain so unless the stimulus or stimuli causing it is interrupted. Often, if this is not done early in the course of the disease, the problem becomes more severe.

*Treatment*:—Either block of the somatic nerve supplying the dermatomes involved or injection of "trigger areas" from which the stimuli evidently arise may relieve the pain. Repeated injections daily or every other day until three to ten injections have been executed may be necessary.

A few points concerning the trigger areas should be emphasized: (1) There may be more than one and time must be taken to find and inject them all. (2) They may be in the area of the involved muscles but in many instances they are not, e.g., in the scapulocostal syndrome the pain may be in the arm while the trigger areas lie in the region of the scapula and the paravertebral rib area. (3) There is a, so-to-speak, "trick" when injecting trigger areas. A haphazard type of local infiltration is usually not effective. An effort should be made before infiltrating to find the spot in the trigger area which is most sensitive and intensifies or duplicates the patient's pain when struck by the needle's point.

*Occipital Headache: Pathogenesis of Pain*:—In most instances this is unknown and no organic reason can be found. In others trauma may have preceded the onset. Irrespective of the cause, in

most instances the greater and lesser occipital nerves, i. e., C<sub>2</sub> and <sub>3</sub> are involved.

*Treatment*:—Block of these nerves unilaterally or bilaterally, depending on the distribution of the headache, at the transverse process of their respective vertebrae often will relieve headache. Usually two to three blocks at two to three-day intervals are sufficient. After this number of blocks, if the headache persists, although relieved during the physiological effectiveness of the drug, ammonium sulphate derivatives such as Dolamin have been injected with marked success in a high percentage of cases.

*Atypical Sciatica: Pathogenesis of Pain*:—In cases where the signs of a tumor in the vertebral cord are absent and myelograms are negative, sciatic pain may occur spontaneously or following trauma. The reason for the sciatica in these cases is difficult to determine but has been attributed to adhesions around the nerves, either in the epidural space or in the vicinity of the intervertebral foramina.

*Treatment*:—This type of case often will have a complete remission of pain following one or two pressure caudals. It is our custom in these cases to inject 25 cc. of a local anesthetic agent. We allow fifteen minutes for it to establish anesthesia and then inject rapidly 25 to 60 cc. of normal saline. The exact amount of saline used is determined by asking the patient to tell us when he feels pain in the shoulder region.

*Acute Thrombophlebitis: Pathogenesis of Pain*:—Thrombosis or inflammation of the vein precipitates a persistent spasm of the other vessels of that limb although they are not primarily involved by the disease. This vasospasm results in tissue hypoxia, edema and a self-perpetuating vicious cycle is established.<sup>14</sup>

*Treatment*:—Block of the sympathetic nervous system of the extremity involved breaks the vicious cycle by releasing the vasospasm, particularly of the collateral circulation. Blocks should be given daily for three days and then every other day until a total of six to ten blocks has been given. The pain usually subsides immediately and in three to five days the size of the extremity may return to normal.

The usefulness of sympathetic block in the acute stage of thrombophlebitis does not reflect its efficacy in the chronic stages. This is particularly true in the lower extremity. Here the block

usually relieves aching only for the physiological effectiveness of the drug employed and in most instances does not permanently alter the chronic edema.

*Miscellaneous Acute Vasospastic Conditions Occurring During Everyday Intravascular Injections:*—At the Mason Clinic severe persistent vasospasm has been observed following: (1) intravenous injection of antibiotics, powerful vasoconstrictors, i.e., Levophed (norarterenol) and solutions containing propylene glycol as a preservative solvent, i.e., Nembutal (pentobarbital); (2) withdrawal of blood for transfusions; (3) cardiac catheterization; (4) the mere attempt to start intravenous fluids and (5) intra-arterial Diodrast injections.

*Pathogenesis of Pain:*—In these cases either the irritation of the adventitia of the blood vessels by the needle point or the endothelium by the injected drug causes a reflex vasospasm.

*Treatment:*—In most instances either one or two stellate blocks for the upper extremity or lumbar sympathetic blocks for the lower, administered within the first 12 hours will release the spasm due to stimulation by a needle. However, if the endothelium of the vessels is irritated or damaged by a sclerosing drug, one block daily for four or five days may be necessary to relieve the signs and symptoms of vasospasm.<sup>15</sup>

*Postoperative Radical Mastectomy Syndrome: Pathogenesis of Pain:*—The postoperative radical mastectomy syndrome is caused by the radical and often mutilating surgery necessary in efforts to cure a malignancy of the breast. Many physicians place great emphasis on the edema of the arm following the surgery but this is in reality merely part of the picture which includes in addition lymphangitis, pain, induration, hypertrophic cicatrix formation, accumulation of fluid, delayed wound healing and limitation of motion.<sup>15</sup> These conditions may act as foci of stimuli which result in chronic vasospasm.<sup>3</sup>

*Treatment:*—Relief of chronic vasospasm in the arm and chest wall may be produced by stellate ganglion block. The earlier the treatment the more satisfactory the results. The block should be performed every other day until a series of three to six blocks has been given and then at weekly intervals until a series of ten blocks has been performed. If deep x-ray therapy is used to supplement surgery, and the arm and

chest wall show evidence of edema, immediate stellate ganglion block therapy is indicated.

Once the edema of the arm has become permanent, i.e., exists eight months or longer, only occasionally will this therapy reduce the edema. However, in most instances it will alleviate any pain and result in marked softening of the brawny hardness of the arm.

*Acute Pancreatitis: Pathogenesis of Pain:*—The true cause of acute pancreatitis is debatable but whatever it is, there results ischemia of the pancreas with edema and tissue necrosis. Unless this pathological processes can be interrupted a vicious cycle is established and severe pain, often unrelieved by large doses of opiates, ensues.

*Treatment:*—Block of the coeliac (splanchnic) plexus not only alleviates the pain by blocking the pain fibers from the pancreas but in addition relieves the vasospasm by blocking the autonomic nervous system. This in turn reduces the edema and leads to remission of the disease. Usually one block will give marked relief but in some instances two or three given on successive days may be necessary for complete relief.

*Reflex Sympathetic Dystrophies:*—The term "reflex sympathetic dystrophy" as used here refers to a heterogeneous group of cases which have many of the same signs and symptoms but a varied etiology. The terms "sympathalgia", "post-traumatic pain", "irritative nerve lesions", "reflex dystrophy", "post-traumatic spreading neuralgia", "minor causalgia", and "post-traumatic reflex troubles" have been used by others to describe what is being included here as reflex sympathetic dystrophies.<sup>3,16,17,18,19,20</sup> Their etiology may be unknown or attributable to myocardial infarction, trauma, cerebrovascular accidents, herpes, diffuse vasculitis, cervical osteo-arthritis, panniculitis or gonorrheal arthritis.<sup>21,22,23,24,25</sup>

*Pathogenesis of Pain:*—The function of the sympathetic nervous system involved in the reflex sympathetic dystrophy syndrome is unknown. However, one of the previously mentioned etiological factors establishes a physiological point of irritation in the heart, brain, or musculoskeletal system from which afferent stimuli arise. These stimuli acting in an undetermined fashion modify the normal pain sensations and alter the normal function of the sympathetic nervous system.

The most important alteration concerning

the sympathetic system seems to be in the realm of vasomotor function but in some instances the sudomotor function is also abnormal. The pain and physical signs may not conform to the known distribution of the peripheral nerves or their roots. Local hyperesthesias are common and often seem to be far out of proportion to the injury sustained. This makes the physician examining the patient skeptical of the reality and severity of the lesion. As the disease progresses the signs of sympathetic dysfunction, manifested by local sweating, a decrease in skin temperature and color changes, such as pallor or cyanosis, become more prominent. In the later stages of the disease trophic changes are prominent. Circulation is definitely impaired, and the skin temperatures are markedly lowered.

*Treatment:*—In a case of reflex sympathetic dystrophy, block of the sympathetic system to the area involved should be instituted early in the course of the disease for the best results.<sup>15</sup> Often in these early cases the first block may result in immediate improvement. The hyperesthesia, pain, immobility, muscle weakness, coldness and cyanosis of the upper extremity disappears, and the patient is very grateful. These signs and symptoms of improvement may last for a few hours or for days, weeks or months. It is interesting to note that the relief from the injection often lasts long after the local anesthetic effect of the drug has worn off. If the pain returns, and it does in many instances, the patient should receive a series of blocks as this may effect a permanent cure. In those cases where the pain returns in a few hours, the first four to five blocks should be given once a day and the next three to five blocks once every three to four days. *Persistent, intensive* therapy is important.

*Herpes Zoster: Pathogenesis of Pain:*—The essential lesion is an acute inflammatory process of the spinal or posterior root ganglion, that is, a ganglionitis.<sup>26</sup> The resultant vasospasm caused by this is an important factor in producing the pain.<sup>27</sup>

*Treatment:*—In the early phase of the disease (1 to 4 days after onset) a series of blocks of the sympathetic nervous system innervating the area, performed daily for four or five days, will usually produce miraculous results.<sup>15,26,27,28</sup> However, if the lesions have been present for a week

or longer, the first two to three sympathetic blocks often must be accompanied with somatic block of the involved dermatomes if *complete* pain relief is to be obtained.

In the post-herpetic pain syndrome sympathetic block is of little value and somatic blocks of the involved dermatome given relief only for the physiological duration of the drug. Root-section is probably the treatment of choice in treating post-herpetic pain although in some instances large doses of vitamin B<sub>12</sub>, i.e., 1000 micrograms daily, may be helpful.

*Acute and Chronic Shoulder Bursitis: Pathogenesis of Pain:*—In the acute stage, trauma or occasionally infection results in a swollen, edematous bursal sac with exudate in the bursa and tendinous shoulder cap. In the chronic stage the bursa becomes greatly thickened and may contain an excess of fluid since the secretory and absorption mechanisms may no longer function normally. There may be some atrophy of the muscles from lack of use, and adhesions in and around the joint may limit motion. These painful stimuli result in a reflex vasoconstriction.<sup>29,30,31</sup> This in turn results in vascular stasis with tissue anoxia and diapedesis of plasma and cellular elements. Thus a vicious cycle is established.

*Treatment:*—In *acute bursitis*, stellate ganglion block therapy should be instituted early in the course of the disease if immediate dramatic relief of pain is to be obtained and if limitation of motion is to be reduced to a minimum.<sup>15,29,30,31</sup> One block should be given daily for the first two to three days and then once every third day until a series of four to seven blocks have been given. While in a fair number of cases the first block may produce marked improvement, it is not unusual for pain to recur after the physiological effect of the drug used in the initial blocks has disappeared. However, with each successive block, the pain tends to become less severe. Intensive, persistent therapy seems to be necessary for success. If the severe pain is not markedly relieved by stellate block, a somatic nerve block of the suprascapular nerve or brachial plexus block should be performed to relieve the pain. It has been noted that it is usually only necessary to give the combination of the two blocks once or twice and after that stellate ganglion block alone is sufficient.

*Chronic Bursitis*:—These cases respond well to stellate ganglion block but results following the initial block are usually not as spectacular as in acute bursitis. The therapy must be persistent, but need not be as intensive as in the acute stage. The first two to four injections are made two to three days apart and then one stellate block is given once a week until a series of six to ten blocks has been completed. The series may be stopped after the sixth block if pain is absent and if range of motion has markedly improved. If the blocks are terminated prior to the sixth block a relapse may follow. Also in chronic subdeltoid bursitis it is often necessary to block the insertion of the deltoid muscle on the humerus or the suprascapular nerve to completely relieve the patient's pain and restore full motion.<sup>15</sup>

#### SUMMARY

This paper emphasizes the following points in the management of pain associated with curable diseases:

- I. Pain, which is usually the cardinal symptom of the diseases discussed here, is in a great number of instances markedly alleviated by therapeutic nerve blocking and, therefore, the block per se should be used as definitive therapy.
- II. Often in these diseases block therapy is tried only as a last resort when all other medical and surgical therapy has been exhausted, and such neglect of a valuable therapeutic measure is condemned. When problems arise in which block or a series of blocks is known to be of value, they should be used immediately in conjunction with other surgical therapy—not as a “last resort”.
- III. The results of block therapy should not be evaluated from the benefit derived from the first block. It is often necessary to perform a series of blocks, i.e., four or more, before dramatic improvement occurs.

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# Combat Psychiatry

## Principles and Practice in the Korean Campaign

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The availability of information and experienced personnel from World War II enabled the U.S. Army Medical Department to establish a combat psychiatric program early in the Korean Campaign. Psychiatrists were assigned to all Infantry Divisions and to hospitals in Korea and Japan. In the spring of 1952, a special psychiatric treatment center was established in Seoul, Korea. Senior officers, acting as consultants, created a training program for young medical officers recruited from civilian life. The majority of medical officers in field units had had only limited training or experience in psychiatry prior to entering the Army. As a result of the training program and the wealth of clinical material, they were able to progress from hospital assignments to the more or less independent assignments as Division Psychiatrist in combat infantry units.

*Principles.*—Although combat psychiatry has no exact counterpart in civil life, its principles are directly applicable to medical care in any situation. It is realistic and practical with emphasis on the functioning of the man within the unit rather than on formal diagnostic categories or detailed psychiatric theory. How a man functions in combat is necessarily in part dependent upon his previous personality development. However, failure to adjust at one time does not always imply severe disease and permanent inability to cope with stress, including even a similar stress at another time. Evaluation of the man and the precipitating stress of his illness must be made rapidly and accurately. Similarly, rapid methods of treatment are necessary.

Adequate evaluation of the stress is impossible unless the medical officer is himself familiar with military life and with combat. Although he should not blindly agree with everything that goes on about him, the combat psychiatrist must

realize the framework in which he is working and must align himself with the forces of law, order and discipline. These forces hold the Army together and help to sustain the individual and prevent psychiatric disability.

It has been emphasized many times that rapid evacuation of psychiatric patients far from the combat area tends to perpetuate the symptoms and disability, converting a transient personality disorder into a severe and often lasting neurosis. Early treatment in the forward combat area is much more effective. Frequently after treatment a man can be returned directly to the same unit. If removal from actual enemy contact is required, he can often be assigned to other duties in the unit from which he came, thus preserving his identification with the group. Experienced battalion and regimental surgeons are able to handle many of the patients themselves without the man even leaving his unit.

It is important to avoid the use of medical channels for removal and disposition of those who do not require psychiatric treatment and who should properly be handled by administrative action. The tendency of some commanders to attempt to make a psychiatric case out of everyone who does not fit perfectly into a unit must be curbed by the adoption of a firm policy by the psychiatrist. The psychiatrist should explain the reasons for this policy and offer constructive suggestions for remedial action.

Survey of the units and situations in which psychiatric cases occur leads the psychiatrist to investigate and recommend corrective measures. Personal contact with other medical officers, with officers who deal with personnel problems, and with unit commanders is necessary for adequate preventive psychiatry. As an example, one psychiatrist found that many cases occurred in men who were new to combat and were unfamiliar with their unit and its personnel. It was suggested that when possible, new replacements should be assigned to units in reserve for

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a period of time prior to the time the unit entered actual combat. Adoption of this policy was followed by a significant lowering of the incidence of psychiatric conditions.

*Treatment Methods.*—In the U.S. 45th Infantry Division, most patients were seen by the psychiatrist at the Division Clearing Station after evacuation through medical channels from battalion and regimental medical installations. Both psychiatric and physical examinations were carried out soon after admission as it was found that occasionally patients with significant physical illness such as the delirium of pneumonia were sent to the psychiatrist. The physical examination also served to reassure the patient. Enlisted medical corpsmen took a social history on the patient and were responsible for the general supervision of the patients on the ward. Patients were expected to have showers and clean clothing when these were available. They were then allowed to rest for 24 hours. Sedation was rarely necessary.

Following the rest, some patients were immediately returned to duty, others were observed further for possible evacuation to the rear. These included the psychotic patients, many of whom had acute and transient psychotic disorders which cleared up after treatment in hospitals. Certain patients with severe symptoms and disability such as hysterical paralyses or amnesias, were treated with intensive suggestion therapy by the Division Psychiatrist. Intravenous barbiturates or hypnosis were used in some of these. Although many such patients required evacuation for further treatment and reassignment, removal of the disabling symptoms at division level was effective in facilitating further treatment at other installations.

The majority were placed in a re-training program which included further interviews by the Psychiatrist. The emphasis of the whole program was on return to duty. Resistance to this program was frequent. It was found that adoption of an attitude of neither rewarding nor punishing patients because of their illness was the most satisfactory method of handling this problem. Positive reassurance and brief discussion of the realities of the Army, combat, and an individual's own precipitating stress were utilized in the interviews. Although past history material was obtained, it was not used in

therapy unless it was considered to have direct and conscious bearing on the current situation.

Using these methods, 78% of the psychiatric admissions in the 45th Infantry Division during 1952 were returned to duty after treatment at division level.

*Changes in the Combat Situation.*—At the time the 45th Division entered combat in December 1951, the original truce talks were in session and the phase of rapid movement was over. Both sides occupied heavily fortified main lines of resistance. There were no large troop engagements, however nightly patrols were conducted. There was continued heavy artillery and mortar fire. Battle casualties and psychiatric admissions were sporadic.

In June 1952, the situation abruptly changed. Two regiments of the division assaulted hills known as "Old Baldy" and "Pork-Chop" in the area between the lines. These hills were part of neither line and had been patrolled and used as outposts from time to time by both sides. Fighting was heavy with frequent enemy counter-attacks. Enemy artillery fire was heavy and there was hand-to-hand combat. The division continued in this battle for the next six weeks.

The intensity of the fighting can be appreciated by realizing that the Division sustained 54% of its battle casualties for the whole year during this period. During the same time, 72% of the psychiatric patients for the whole year admitted. Severe anxiety reactions, dissociative states, and exhaustion cases were seen in rapid succession. Certain of these cases have been described in detail elsewhere.<sup>1</sup> Despite the heavier patient load, the treatment program was maintained and 77% of the admissions were returned to duty after treatment, many returning to units still engaged in the fighting. Other patients were treated at the Regimental Collecting Station without referral to the psychiatrist. The medical officers at this level were well aware of the psychiatric problem and handled most of the milder cases themselves despite the simultaneous heavy load of battle casualties.

In mid-July, the Division was relieved by another unit and moved into reserve. There was an abrupt fall in the psychiatric admission rate.

<sup>1</sup>Norbury, F. B. Psychiatric Admissions in a Combat Division 1952. Medical Bulletin of the U.S. Army Far East I: 130-133, July 1953.

This period was utilized for integration and training of new replacements including Korean soldiers who were assigned alongside of Americans in each of the combat units. The integrations of Koreans into American units was surprisingly easy and effective. Few were seen by the psychiatrist primarily because those who proved ineffective were sent back to the Korean Army by administrative action. Those who were sent for psychiatric examination presented a difficult problem in communication. Exact diagnosis was impossible. The author relied largely upon his interpreter, a highly intelligent former university student, who rapidly grasped the principles of military psychiatry with no previous formal training.

In September, the Division returned to combat, again to a heavily fortified line facing a similar enemy line. Patrols were resumed, and localized heavy fighting occurred around outposts or exposed portions of the line, but the campaign was largely static. Neither battle casualties nor psychiatric admissions were numerous.

#### DISCUSSION

Glass<sup>2</sup> has discussed the factors which lead to the development of psychiatric cases in combat with reference to the Korean campaign. He concludes that group identification, motivation, and leadership are the sustaining forces in the maintenance of emotional adjustment in combat. It is apparent that these sustaining forces for the individual are also the ones which determine a unit's combat effectiveness. The goal of the military psychiatrist is therefore the same in principle as the commanding officer's goal.

Individuals at one time or another attempt

to avoid responsibility by resort to trivial physical complaints, by litigation, or simply by running away. Others attempt the same thing less directly and less consciously and develop the multiple manifestations of anxiety. Encouragements of these efforts by excessive sympathy, by rapid removal from the responsibility, or by overzealous attempts to uncover an individual's life problems are not effective in restoring stability or even in relieving symptoms. Threats, punishment, or chastisement are also ineffective. Appeals to patriotism or intellectual discussion may succeed in recruiting campaigns but are seldom helpful in restoring the psychiatric patient to health and duty.

Continued application of the principles of reality by word and action is very effective in these acute and temporary disorganizations of the personality. Reactions similar to acute combat neuroses are not uncommon in civil life. Examples are panic, acute grief reactions, and the depressions which follow upon real or imagined failure. The important points in management are early supportive treatment with realistic goals and special care to prevent exaggeration or continuation of the disability. Extensive psychiatric training is not necessary for use of these methods. Promptly and properly handled, the reactions carry a favorable prognosis.

#### SUMMARY

In this discussion of combat psychiatry in Korea, the principles and methods of management have been presented. It was emphasized that early treatment in the forward area by simple measures including rest and brief psychotherapy is effective in promoting recovery and return to duty.

<sup>2</sup>Glass, Albert J.: Current Problems in Military Psychiatry. J.A.M.A. 150:6-9 (Sept. 6, 1952).

# Capillaries

## A Symposium

**Hubert R. Catchpole, M.D., Associate Professor of Pathology; Robert M. Kark, M.D., Professor of Medicine; Alfred A. Schiller, M.D., (Moderator) Associate Professor of Physiology; Max Samter, M.D., Associate Professor of Medicine, and George Ungar, M.D., Research Associate in Physiology.**

*INTRODUCTION: Dr. Alfred A. Schiller.*—Recent experimental observations have focused our attentions upon the role which the capillary bed plays in the maintenance of health and in the pathogenesis of disease. It is the purpose of this seminar to present several facts of work now in progress.

We would like to begin our roundtable by putting the cart before the horse, so to speak, in presenting work which emphasizes the clinical significance of impaired capillary function.

*Dr. Robert M. Kark.*—The studies which we have carried out in our laboratories emphasize the importance of capillary membrane in the genesis of edema. Our initial observations on the fate of intravenous injections of human serum albumin to patients with cirrhosis and ascites has led us to suspect that a defect in the capillary membrane was present. The reason for this suspicion was the rapid passage of albumin into the ascitic fluid. We extended our studies by using radioactive ( $I^{131}$ ) human serum albumin. Our findings, as well as the results of our recent studies in patients with congestive failure, confirm the conclusions of other investigators that the albumin space in these patients is increased while the red blood cell space remains constant.

*Dr. Schiller.*—The defect which Dr. Kark has described, might be due to the simple failure of a membrane or to a very complex impairment of the regulations which determine the passage of fluid from the vascular bed into the tissues. Each of the speakers who participate in our discussion have investigated certain phases of capillary function which are related to the field of their particular interest. I am certain, for instance, that the desire to understand positive

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skin reactions in allergic patients has been responsible for Dr. Samter's studies on the effect of histamine and histamine liberators on the human skin.

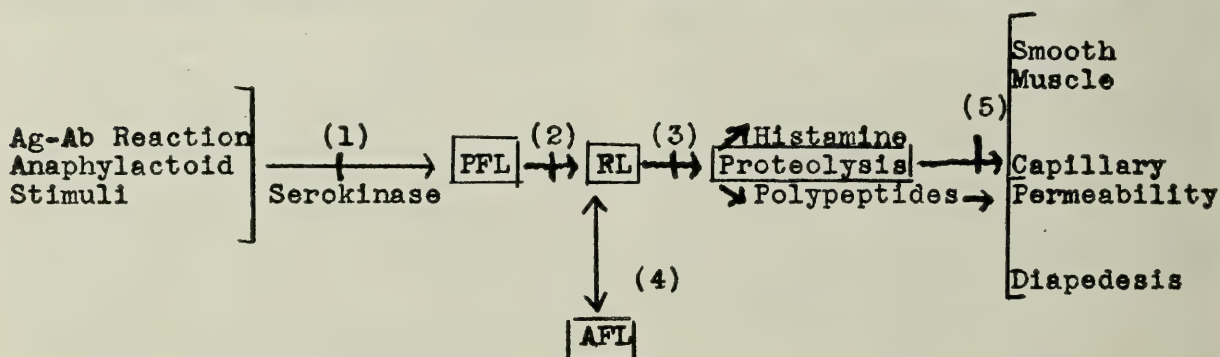
*Dr. Max Samter.*—We have attempted to approach the problem of the capillary membrane by studying some phases of Lewis' triple response which combines arteriolar dilatation with increased capillary permeability. Histamine elicits the triple response, in part directly, in part through an axone reflex. During the past two years, a number of substances have become available which liberate histamine from its fixed into a free and active state without proteolysis. The substances include Dextran, polyvinyl pyrrolone (PVP), and a condensation product of formaldehyde and p-methoxyphenethyl methylamine (Compound 48-80). Comparative studies with injections of histamine and Compound 48-80 indicate (1) that individuals differ widely in their response to the injection of histamine phosphate and Compound 48-80; (2) that each individual, however, shows approximately the same response to the injection of the compound as to the introduction of exogenous histamine phosphate.

It is likely, therefore, that either the response of the vascular tree, i.e. arterioles, capillary membrane, and venules, is characteristic for each individual or that each individual has a characteristic rate of degradation of histamine which remains the same whether histamine is introduced as such or liberated from its precursor. We are at present engaged in studies to answer this question.

*Dr. Schiller.*—The allergic reaction represents a rather specialized form of information. The role of the capillaries in the more general aspects of the inflammatory response has been elucidated by Dr. George Ungar in the studies in which he is about to report.

*Dr. George Ungar.*—During the last two decades, the inflammatory reaction has become an object of a joint study of biochemists and physiologists. It now appears possible to suggest a hypothesis which explains this reaction — its mechanisms, in general, and the role of capillaries, in particular.

Numerous observations suggest that the intermediate step between tissue injury and inflammation is characterized by the breakdown of protein molecules. It is probably that activation of the fibrinolytic system is the central change. The following diagram illustrates the sequence of events as now assumed to occur:



**PFL profibrinolysis, FL fibrinolysis, AFL Antifibrinolysin.**

The fibrinolytic process (activation of profibrinolysin, appearance of free fibrinolysin, protein breakdown and histamine release) have been shown to occur in the course of the anaphylactic and anaphylactoid reactions and also in thermal injury of the lung and skin. Good correlations were demonstrated between the proteolytic process and histamine release and also between proteolysis and the local inflammatory reaction (measured in terms of edema).

Successful attempts have also been made at explaining the action of anti-inflammatory agents (salicylates and related drugs, antiphlogistic hormones, etc.) in terms of their effect on the fibrinolytic process.

It is probably that the two homeostatic functions of the capillary wall-expulsion of foreign material and retention of the normal content of blood — are performed largely through the

fibrinolytic system.

*Dr. Schiller.*—The exchange of fluid between vascular bed and tissue is probably controlled by reactions within as well as without the capillary bed. The work of our next speaker, Dr. Catchpole, has been concerned with the physical and chemical changes of the environment in which capillaries exist.

*Dr. H. R. Catchpole.*—We have studied the role of certain extra-capillary structures in the passage of fluid and dissolved substances from blood plasma to tissue. These structures include the capillary basement membrane and the homogeneous ground substance of connective tissue. They contain, normally, highly aggregated water and alcohol-insoluble mucoproteins and mucopolysaccharides as an integral part of their composition. These substances are negatively charged colloids which function as exchange resins for cations. The connective tissue matrix, under the

influence of trauma or stress, after hormone stimulation, and in numerous pathological states, tends to become less aggregated, and water soluble, and varies its properties as an exchange resin and its affinity for vital dyes. Thus, connective tissue in and around fast growing tumors shows a prompt uptake of Evans blue, in contrast to a negligible uptake in normal connective tissue, or that of slow growing tumors. In rats with a pulmonary edema induced by thiourea, Evans blue localizes in basement membrane, ground substance and elastica of alveolar walls, but not in the protein-containing extravasated edema fluid in alveoli: thus here, chemical combination between dye and altered connective tissue appears to be the important variable, rather than capillary permeability *per se*. In rat ovaries stimulated by gonadotrophin, there is an enhanced uptake of dye by connective tissue of the theca; normal

animals exposed to equal or greater amounts of dye for ten times as long failed to show as intense a dye uptake, indicating that blood flow (total dye supply) is not a limiting factor. The focus of dye uptake parallels mucoprotein diagggregation as shown by solubility studies, in several situations where connective tissue has been experimentally affected. Electrometric studies (not discussed at the present symposium) have shown that the connective tissue, as it varies from more dense to less dense, either normally or following stress, hormones, etc., varies in its selective interaction with the physiological cations. These relations have been expressed in a series of nomograms.

We thus regard capillary permeability as being inseparably linked with certain properties of extracapillary structures: to take up molecules by combination, and ions by virtue of the exchange resin nature of the matrix.

*Dr. Schiller.*—Our roundtable so far has emphasized the factors which influence capillary permeability. Considering the magnitude of the various factors which regulate the exchange of material between vascular bed and tissues, one wonders how much capillary permeability is actually involved in, for instance, edema.

The primary forces effective in moving solvent and solute across the capillary wall are gradients of hydrostatic pressure and solute concentrations. Blood flow through the capillaries, filtration and diffusion surface area, and the permeability of the capillary wall to solutes are additional modifying factors. Further complexity results from the knowledge that certain capillary beds are more permeable to plasma proteins than others, and the distribution of blood changes patterns in various physiological and pathophysiological states.

Since the capillary wall is slightly permeable to plasma proteins, a change in one, or any combination of the above factors, can alter the rate of transcapillary protein movement. Therefore, a change in rate of disappearance from the blood or accumulation in an extravascular compartment, of labeled plasma protein is not itself a criterion of capillary permeability change unless other factors operative in protein movement taken together, can be shown to be essentially unchanged. However, accelerated protein movement can be looked upon as being *consistent* with an

increase in capillary permeability when there is reasonable assurance that capillary hemodynamics have not been appreciably altered in a direction to give the same result — a difficult assumption at best!

Concerning the status of capillary permeability as a pathogenetic factor in disease, the following synthesis is offered. Technically acceptable animal and/or clinical investigations of states of severe hypoxemiz, congestive heart failure, nephrosis, and shock fail to provide evidence of a *generalized* increase in capillary permeability to plasma proteins. Sustained stresses capable of producing widespread increase in capillary permeability, e.g., severe hypoxemia, are incompatible with chronic survival of the intact organism due to earlier irreversible damage to oxygen sensitive vital tissues (brain, liver) before the more hardy endothelial cells dysfunction. However, it is recognized that capillary permeability may be increased *locally* in situations where toxic substances in high concentration are locally released or absorbed, e.g., inflammatory states.

Further, the high degree of capillary impermeability to plasma proteins confers on it the physiological role of retaining colloid in the vascular tree. Hence, the role of water retention and maintenance of blood volume is the important attribute of capillary impermeability to plasma proteins. There is no body of evidence to indicate that blood volume is regulated through a mechanism which varies the leakage rate of plasma proteins from capillaries. Therefore, the hypothesis is advanced that capillary permeability is not a homoeostatically regulated function like blood pressure, but rather a relatively fixed property of vital endothelial cells, more nearly resembling the physical properties of elastic fibrils, or the "all-or-nothing" behaviour of striated muscle.

Clinical corollaries of this hypothesis are:

(1) A generalized increase in capillary permeability is incompatible with chronic survival of the organism and therefore does not persist in chronic disease states.

(2) Edemas resulting from chronic disease of an organ system can usually be explained by water-electrolyte disturbances, and/or alterations in blood or lymph capillary dynamics, without invoking capillary permeability as a pathogenetic factor.

# Surgical Implications of Acute Pancreatitis

Chas. E. Baldree, Jr., M.D., F.A.C.S.  
Belleville

The past twenty years has shown increasing familiarity with the life history of acute pancreatitis. Its clinical manifestations and the laboratory diagnostic procedures which have been developed have led not only to increased frequency but also to increased accuracy of clinical and surgical diagnosis of the disease. These experiences have led to the realization that chronic pancreatitis particularly is a rather common disease which must be considered routinely in the differential diagnosis of the disease of the upper abdomen. Unfortunately therapy has not improved with the same progress as diagnosis. The increased accuracy of diagnosis has permitted a more intelligent appraisal of the various therapeutic measures and promises much for the future.

Although its etiology is obscure it is known to be associated frequently with biliary tract disease, alcohol excess, and obesity. I would like to review briefly the symptoms of acute pancreatitis its clinical and laboratory diagnosis, complications, and treatment in so far as surgery is indicated.

Acute severe epigastric pain midline, nausea, and vomiting in individuals in middle age should warrant a consideration of diagnosis of acute pancreatitis. The disease may occur at any age but most common in middle age groups. The pain mid epigastric remains so with some radiation to each side of midline more to the left than right.

Incidence of acute pancreatitis varies according to statistics given by Probst and the St. Louis Group, [1 in every 600 hospital admissions] to the figures by Falling and Plain in which they report 1 in 10,000, however, the latter figures were based on findings at operation and preoperative diagnostic determinations of the blood diastase were not performed. Hence the extreme value of discovering mild or transi-

ent forms of acute pancreatitis. This can be done by routine blood diastase determination in any case in which pain in the upper abdominal area is present.

The association of diabetes with acute pancreatitis also varies. A thorough evaluation of carbohydrate metabolism in all patients suffering from acute pancreatitis should be done. Acute pancreatitis complicated by diabetes carries a high mortality. Pre existing diabetes complicated by acute pancreatitis is more deadly still. Schumacher stated that of nineteen recorded cases only one survived.

What constitutes a diagnosis of acute pancreatitis? The findings of an elevated blood or urine diastase during an episode of acute abdominal pain. The height of blood diastase has little relationship to the severity of the disease yet bears a definite but inconstant relationship to the duration of the attack. A diastase level may vary unpredictably, up tonight, down tomorrow, level for a day or two then up in a spike and quickly down.

A diastase level may return to normal in 48 hours. The absence of an elevated value three to four days after the attack does not rule out acute pancreatitis. The height of the diastase blood level depends on how soon after onset of pain the blood is tested; if within twenty-four hours the value will generally be in the neighborhood of 1,000 to 1,500 Somogyi Units per 100 cc. Values of 1,500 to 3,000 are considered pathognomonic of acute pancreatitis. Lesser values may be found in (1) renal retention (2) cancer of pancreas (3) perforation of duodenum (4) obstructive lesion of salivary ducts and suppurative salivary adenitis.

What are indications of surgery? Surgeons of the St. Louis University Group are practically unanimous in their opinions that operation is not indicated in the treatment of acute pancreatitis itself. In an occasional instance, however, it may be necessary to operate in the presence of signs of spreading peritonitis caused by hemorrhagic fluid with a high amylase content. Simple drainage of the pancreatic area, some-

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From the Dept. of Surgery, St. Louis University Medical School.

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times accompanied by drainage of the biliary tract, is the technique of management. Surgery is reserved for the complications of pancreatitis, pseudo cysts, pancreatic abscess etc. An intermittent fever seven to ten days after onset of acute process, the findings of a tumor mass make the diagnosis obvious, occasionally the mass is not palpable but can be found on x-ray by the widening of the duodenal curve or displacement of the stomach in an upper GI study.

#### Case Report

23 year old female admitted St. Louis University OB clinic November 14, 1951 6 months pregnant 5 years ago normal pregnancy

Unable to tolerate fatty foods

5 previous attacks epigastric pain which subsided spontaneously

Admission: elevated wbc, no fever, tenderness epigastric area, serum amylase 1,066 Somogyi Method—X-ray abdomen revealed several calculi in region of GB

Admission diagnosis—Acute pancreatitis

Treatment—Demerol 100 mg, Banthine 50 mg TID, continuous gastric suction Electrolyte balance maintained 24 hours improved, Penicillin added to treatment 2 days later serum amylase 2,133 units

4 days later 1,600 units

11th day 320 units

13th day discharged

Readmission 1 week later

Amylase 2,280 units, some epigastric medline pain following big pork meal

Same regimen instituted—suction, Demerol, Electrolyte balance watched, glucose IV Following day Amylase 640 II days later discharged low fat diet RX avoided meats—Diet fruits, cereal and juice precipitated attack on Feb. 3 severe epigastric pain, vomiting 1 hr later admission to hospital

February 3 admission—Amylase 3,200 units Same therapy instituted following day improved Amylase 2100 units food allowed 2 weeks later Amylase 200

February 16, 1952 transferred to obstetrical service for induction of labor

February 18, 1952 after induction membrane ruptured and pitocin given delivered 5 pound 8 ounce male (Anesthesia Nitrous oxide combined with procain 1% and hyaluronidase)

16 hrs after delivery attack severe pain epigastric region, nausea and vomiting 6 hrs later BP 110/70 Pulse

rate increased shortly thereafter BP 98/78 pulse rate increased from 120 to 160 Patient became cyanotic extreme pain, evidence of general peritoneal irritation and tenderness—tenderness partially relieved by paravertebral block (novacaine) T7 to L I

Shock treated laparotomy—No evidence of fat necrosis GB filled with many stones Inferior aspect transverse mesocolon, duodenum, head of the pancreas and region of the common bile duct showed a severe degree of greenish-yellow edema

Fluid from region of common bile duct collected for amylase determination which gave a reading of 80,000 units—serum amylase done at the same time gave reading of 3,800—One stone removed from common duct and GB removed common duct closed about a T tube—condition severe for a few hours thereafter improved no pain

Following day serum amylase 1,600 units

Bile from duct tube 246 amylase units

Urinary amylase 1,070 units

T tube drainage 300cc daily

10th day clamp off T tube no trouble

Cholangiogram 10th day following surgery showed questionably sluggish flow into the duodenum.

Cholangiogram 6 months after surgery was normal.

Pancreatitis in pregnancy rare 65% of reported cases occurred in puerperium

(?) Suggesting that something happens at birth Change in blood supply to pancreas Change in hormone concentration—Autonomic nervous influences Mechanical pressure in region of pancreas and common bile duct

#### DISCUSSION

Chairman Rogers: Are there any questions?

Dr. Brody: I wonder if I may ask a question? Do you prefer the common duct drainage rather than cholecystectomy. In your experience, which do you prefer? Another thing I noticed was that in one of your cases the T-tube was left in for three months. Is that about the usual time which you may expect to maintain drainage?

Dr. Charles E. Baldree, Jr., Belleville, Ill.: It is our present practice, Dr. Brody, to maintain drainage for several months, until the cholangiogram informs us of free passage into the duodenum without an increase in the serum amylase, and there is no discomfort when it is done.

The author wishes to thank Dr. C. Rollins Hanlon, Professor and Head of the Department of Surgery, St. Louis University Medical school for the use of slides used in preparing this paper.

# The Part of Physicians in the Eradication of Tuberculosis in Illinois

**J. Arthur Myers, M.D.**  
**Minneapolis, Minn.**

Nothing but illness could have kept me from accepting Dr. George Turner's invitation to meet with your group because I firmly believe that the ultimate solution of the tuberculosis problem, namely eradication, will be accomplished only when the medical profession individually and collectively determine that it shall be so.

The Illinois State Medical Association has adopted what I consider the ideal program which consists of a committee on tuberculosis of the state association and a committee in each county or municipal society. This makes it possible for all tuberculosis problems to be considered by state and local organization committees and in turn recommend action by their entire groups. There is no finer array of physicians in the world than those who compose this state association. Your organization consists of the very best in general practice as well as all of the specialties. You and your allies possess every facility for eradication of tuberculosis.

The medical profession of Illinois early saw the need of an official agency to which it could turn in solving contagious disease problems including tuberculosis, hence it strongly supported a movement for a state board of health, which was established in 1877. The Board has the authority to take over any contagious situation, including tuberculosis, which the practicing physician does not care to or does not have time to manage. With its fine division of tuberculosis control the Illinois State Board of Health is playing an important role in the program leading to eradication of this disease.

Long ago the physicians of Illinois realized that tuberculosis never would be controlled unless persons with contagious disease were isolated so their associates would not be infected or reinfected with tubercle bacilli. A sanatorium move-

ment was begun and the first institution exclusively for tuberculous patients was established at Springfield by Dr. George Thomas Palmer in 1913. Then came Chicago Municipal in 1915, Rockford Municipal in 1916 and Peoria Municipal in 1919. This movement was continued and accentuated until today a fine array of sanatoriums exists in this state. I have been told that in a few areas you do not have enough sanatorium beds. In such places the medical profession would do well to support movements leading to an adequate number. It is a well established fact that as long as contagious cases of tuberculosis are not isolated a community cannot expect to eradicate this disease. It is absolutely essential that a bed be available promptly for every person in this state who has contagious tuberculosis.

The foresight of the medical profession was again manifested when organizations were recommended to disseminate information concerning this disease to the entire citizenry of the state. This resulted in the Illinois Association for Prevention of Tuberculosis in 1905 now known as the Illinois Tuberculosis Association. The membership of this organization is composed of professional and non-professional workers with a preponderance of the latter. It derives most of its funds from the sale of tuberculosis Christmas Seals. For many years it has done excellent educational work throughout the state and thereby has played a large role in bringing about satisfactory legislation, increasing the number of sanatorium beds, and creating a cooperative citizenry lending support to tuberculosis control activities everywhere. In the State Medical Association's tuberculosis eradication program there is no more valuable or helpful organization than the Illinois Tuberculosis Association.

Inasmuch as the bovine type of tuberculosis is transmissible to animals, particularly from cattle to man, from man to man and from man back to animals, the futility of attempting to control the disease in people and at the same

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time not controlling it in animals and vice versa was obvious. Therefore, it was just as necessary in Illinois that a tuberculosis eradication program among animals be affected as one among humans. Tuberculin testing of animals was early done in this state and when the United States Bureau of Animal Industry launched a nationwide tuberculosis eradication campaign in cattle in 1917, the veterinarians of Illinois were quick to accept the recommendations and adopt the county as a unit on a state-wide eradication program basis. Whenever the testing with tuberculin of all of the cattle of the county resulted in only 0.5 of 1 per cent or less reactors that county was officially designated as a modified accredited area. The first seven Illinois counties were accredited during the period January 10 to July 12, 1927. By October, 1934 every county had been so accredited and the entire state was designated a modified accredited free area. Since that time the incidence of tuberculin reactors among cattle has been so reduced that in 1952 testing revealed that only 0.19 per cent and the first few months of 1953 only 0.12 per cent of the animals were infected with tubercle bacilli. Despite this low incidence the veterinary medical profession continues its periodic tuberculin testing of the 3,869,000 cattle of Illinois. Veterinarians know full well that any animal which reacts to the tuberculin test regardless of apparent good health is potentially a contagious animal, and therefore, as long as such an animal exists there is a tuberculosis problem in this state. Veterinarians have gone so far ahead of our profession with their tuberculosis eradication programs that there is now much more likelihood of animals becoming infected from contact with tuberculous people than from tuberculous animals.

It is my understanding that this audience consists for the most part of members of committees on tuberculosis of state and county medical societies of Illinois. I have no doubt that your committees are now engaged in excellent tuberculosis work; therefore, I feel at home in your presence. Having been chairman of the Committee on Tuberculosis of the Minnesota State Medical Association for 28 years I shall risk relating some of our activities. In 1940 our committee recommended that the State Medical Association establish a state-wide tuberculosis control program and that each physician's office become a

tuberculosis center. The officers of each county medical society appointed a committee on tuberculosis. The state committee has held meetings frequently and the minutes are sent to the members of the committees on tuberculosis of all local societies. Annually the county society members of the committee on tuberculosis meet with the state committee in precisely the same manner as you are doing today. On that occasion various state and local tuberculosis problems are discussed and often recommendations are made for their attempted solutions. I shall relate just a few of the special projects which our committees have tried to develop.

#### *Accreditation of Counties*

That which seems to have been most effective and still offers the greatest promise has consisted of accrediting counties with reference to accomplishments in tuberculosis control among humans. The idea was borrowed from the veterinarians because they had found that accreditation of counties was an extremely effective method of stimulating interest and activity on a county-wide basis, taking advantage of local pride. Our committee established two qualifications which any county would have to meet before accredited: 1. Average mortality rate for the past five years must not be more than 10 per 100,000 population. 2. The tuberculin test must be administered to at least 90 per cent of the seniors in the high schools throughout the county. This qualification is met if not more than 10 per cent react to the test. The first county was accredited on December 11, 1941 and the 25th on April 20, 1953. Enough counties have now practically qualified to bring the number to 64. This will be accomplished just as fast as details can be worked out and arrangements made for accreditation ceremonies. A considerable number of the remaining 23 counties in the state will probably qualify within the next two years and it appears that within five years all of the 87 counties will have been accredited. This project has done exactly what we had hoped it would, namely, stimulate interest and activity, take advantage of local pride with much more rapid promotion of the tuberculosis eradication program than before the project was instituted.

This accreditation program has been a joint enterprise between the State Medical Association and the State Board of Health. The State Tuber-

culosis and Health Association has done a tremendous amount of educational work which has greatly facilitated the program. This organization, working with the local medical society committees on tuberculosis, has done much to assist in testing with tuberculin and arranging programs for accreditation ceremonies.

#### *Certification of Schools*

Another activity of a somewhat similar nature consists of certifying schools with reference to tuberculosis control work in progress in cooperation with the American School Health Association. Three members of our State Committee on Tuberculosis developed and are directing this activity. They established qualifications by which any school or system of schools might qualify for certification. This probably has stimulated more interest and resulted in greater activity than even the accreditation of counties in that such organizations as Parent-Teacher Associations become involved and often practically every citizen in the area regardless of age participates in the program. It is rapidly spelling the doom of the tuberculous teacher, bus driver or other personnel spreading unsuspected tuberculosis to fellow personnel members, children and students as well as other associates in the community. More than 2,000 schools have these certificates displayed on their walls and there is actual clamouring on the part of many other schools to meet the qualifications. In fact, this project of certifying schools can be conducted at the same time as the county accreditation program is in operation.

#### *Phenomenal Accomplishments*

The accomplishments in tuberculosis control have been phenomenal in Illinois. The mortality rate has decreased to almost unbelievably low levels. Rates of 20 per 100,000 outside of Chicago and only 30 per 100,000 in this great city is beyond the fondest hopes and most pleasant dreams of those who worked here a quarter century ago. A mortality rate reduced to 30 in the city of Chicago signifies greater effort and better accomplishment than the lower rates now prevailing in such states as Iowa, Minnesota and Wisconsin. The problem here has been much more grave and its solution far more difficult than it ever was in the less densely populated areas.

In this city a large volume of credit must go

to the Tuberculosis Institute of Chicago and Cook County, which is the Tuberculosis Christmas Seal organization and is comparable to a state tuberculosis and health association. This Institute, founded in 1906, has long done excellent educational work, often under most trying circumstances, but it has succeeded and will continue to be an important factor in the future.

#### *Less Than Halfway*

Despite the fine accomplishments in this state, the medical profession and its allies have not yet reached the halfway mark to the tuberculosis eradication goal. The remainder of the road is more difficult than that which has been traveled. Indeed a gigantic problem lies ahead. Although the number of deaths and the number of sick people has decreased phenomenally a great many persons now living were exposed to people with contagious tuberculosis or were infected from cattle and tubercle bacilli invaded their bodies earlier in life. In many of these persons there still reside foci of living tubercle bacilli as can be demonstrated by the tuberculin reaction. All such persons despite the clarity of x-ray films of their chests and their excellent state of health at the moment are potential cases of clinical and contagious tuberculosis. Although this condition exists in a few children and young adults, it is in preponderance in the older age groups who were less protected against tubercle bacilli as children.

If not now, certainly very soon, there must be a change in emphasis in the tuberculosis eradication program of Illinois. Until now the major part of work has been devoted to finding persons with gross tuberculous lesions as manifested by symptoms and physical signs they present or the shadows cast on x-ray films. Although this kind of work has been essential and should be continued, emphasis must shift to locating all persons who have tubercle bacilli in their bodies, since such individuals are potential cases of clinical and contagious tuberculosis. This kind of attack is made upon the tubercle bacillus itself rather than upon the destruction it has caused. By this method all the tubercle bacilli of a county or the entire state can be corralled and the medical profession and its allies will know in whose body they exist and where to expect clinical disease to appear.

This means that county-wide tuberculin test-

ing surveys must be conducted, including persons from birth through senility. Inasmuch as every characteristic tuberculin reactor has living tubercle bacilli in his body this method is just as accurate in locating the whereabouts of tubercle bacilli in a community as finding them by the microscope or cultural and inoculation methods.

When tuberculin reactors, particularly adults, are examined periodically, including x-ray film inspection of their chests, those destined to develop clinical lesions in their lungs may have such areas of disease detected by the x-ray shadows they cast on an average of more than two years before they become contagious or cause illness. Thus after gross lesions have developed so they can be detected by the shadows they cast on the x-ray film the tubercle bacilli are still corralled in the individual's body. If proper therapeutic steps are taken during this period the tubercle bacilli may be held within the individual's body and thus prevented from reaching the outside world to set up habitations in the bodies of other people and animals.

While there is good evidence that all tubercle bacilli may die in the bodies of some persons there are many individuals in whom they remain alive and virulent throughout life's span. Therefore, if all new tuberculous infections were stopped immediately those who have been infected in the past constitute a serious tuberculous problem for many future decades. It is only when they are prevented from developing contagious disease and finally carry their tubercle bacilli to the grave that one may hope for eradication of tuberculosis. When people stop dying and when there is no longer anyone ill from this disease there will still be a serious problem among those who react to tuberculin. When only a few persons react to tuberculin they and their associates are in danger. This is just as true of people as it is of animals. It is only when no one reacts to tuberculin that the eradication goal has been attained in any place.

Already there are sizeable areas in the United States where no child of school age reacts to tuberculin. This indicates eradication of tuberculosis through the school age level.

While tuberculin reactors mainly in the older age group are being kept under close surveillance by periodic examinations all nonreactors in the

community, including children, should be tested with tuberculin periodically in order that any who become infected will have this condition detected promptly. Any individual who converts from a nonreactor to a tuberculin reactor has been in contact with a person who has contagious tuberculosis. This has occurred since the last testing with negative result. The contagious case may be a previously unsuspected one. It may be a person who has recently moved into the community or it may be a local adult tuberculin reactor whose examinations have been neglected. Again the recent convertor may have been out of his community working or vacationing and contacted a contagious case. In any event a careful search should be made among the adult associates to find the person responsible for the infection of the recent convertor. This convertor, whether child or adult, should be promptly examined and if no clinical disease is found should be placed in the group receiving periodic examinations.

It is possible that the best treatment for tuberculosis in the near future will be a bacteriocidal drug which will be administered to children and adults alike just as soon as they are found to have become sensitive to tuberculin. At this time the lesions are small and vascular and one might expect to sterilize them with such a drug. Indeed it is possible that combinations of our present drugs including streptomycin, para-aminosalicylic acid and isoniazid may result in the destruction of all tubercle bacilli in fresh lesions if administered sufficiently long.

If tuberculous lesions are not detected until they are large and dense enough to cast x-ray shadows the best opportunity has passed to sterilize them even if a bacteriocidal drug becomes available. By this time their vascularity has been so reduced that it is difficult if not impossible for tubercle bacilli to be reached by a drug in the blood stream. Hence it behooves the physician to administer the tuberculin test universally since a reaction detects the presence of tuberculosis in the human body earlier than any other phase of the examination. Starting with this first manifestation of tuberculosis and carrying through insures the earliest possible diagnosis of any clinical disease which may subsequently evolve.

## SUMMARY

1. The medical profession of Illinois and its allies possess all of the knowledge, the ability and the facilities to eradicate tuberculosis.

2. Among important allies are your excellent State Board of Health, your splendid sanatorium staffs and their institutions, your State Tuberculosis Association and Tuberculosis Institute of Chicago and Cook County and numerous county tuberculosis societies, your splendid nursing profession and social service organizations, your superb veterinary profession, etc., etc.

3. Phenomenal accomplishments have already been achieved, but you are less than half the distance to the tuberculosis eradication goal.

4. A major part of the tuberculosis work of the past has consisted of finding and treating gross lesions, and preventing their hosts from disseminating tubercle bacilli.

5. In many areas now and in the whole of Illinois soon, a change of emphasis is due. While the findings of persons with gross lesions by such procedures as x-ray inspection of the chest, isolating and treating such individuals must continue and even be intensified, major emphasis must be placed upon seeking out tubercle bacilli wherever they exist and keeping them corralled. To date this is the only known way of promptly stopping the dissemination of tubercle bacilli.

6. The tuberculin test detects the presence of tuberculosis earlier than any other phase of examination. Every person who reacts to tuberculin has tubercle bacilli containing lesions in his body, even though in excellent health and with clear chest x-ray films. All such persons are potential clinical and contagious cases of tuberculosis.

7. When one finds a person who reacts to tuberculin, one has located tubercle bacilli just as certainly as though they are seen under the microscope or are grown in culture medium or in animals.

8. Only persons who react to tuberculin, therefore, develop gross clinical lesions. Accordingly

every person, regardless of age, who reacts to tuberculin, should be promptly examined, including x-ray film inspection of the chest. If gross lesions are not in evidence they may evolve at any subsequent time. Thus at least annual re-examination should be made.

9. When periodic examinations are made of tuberculin reactors, particularly adults, clinical lesions destined to develop in the chest can usually be found two years or longer before they cause symptoms or become contagious. Thus the tubercle bacilli are still corralled in the individual's body. If treatment is administered promptly, both illness and contagion can usually be prevented.

10. There is no shortcut to the tuberculosis eradication goal. Every person who is now infected and therefore is a tuberculin reactor must be examined periodically as long as he lives. This applies to all who henceforth become infected with tubercle bacilli. Many persons now infected with tubercle bacilli will be living when the 21st century opens. Therefore, if all infection were stopped today, the disease could not possibly be eradicated in Illinois during this century. However, if all persons now infected were kept under adequate observation the eradication goal could be within shouting distance of the workers when the 21st century begins.

11. We must gird for a long strenuous fight just as "a walking journey of a thousand miles begins with a single step" our long journey begins with promptly putting into operation all that we know about tuberculosis and diligently pursuing the tubercle bacillus thereafter.

12. The interest and activity of the public must be aroused, stimulated and perpetuated everywhere. Accreditation of counties with reference to accomplishment in tuberculosis control, certification of schools on the basis of tuberculosis work in progress are excellent methods of obtaining all out support of the tuberculosis eradication program.

# Hospital Management of Bleeding Emergencies in Gynecology and Obstetrics

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The field of obstetrics and gynecology is uniquely characterized by the frequent occurrence of vaginal bleeding which can vary from that of a normal menstrual flow to one of exsanguinating proportions. Many of the problems encountered in this segment of medicine are associated with the proper management and termination of these situations. Obviously, the first step in their management is establishment of a proper diagnosis, since hemorrhage is not an entity in itself but merely a symptom of some other etiologic pathology. Since it is not within the scope of this discussion to dwell upon the diagnostic problem, this very important factor will be unwillingly neglected. This paper will be limited to procedures involved in the management of the more severe forms of hemorrhage encountered in the gynecologic and obstetric patient.

To maintain a degree of organization, the bleeding problems will be separated into those of gynecological nature, including the first trimester of pregnancy, and those usually encountered late in pregnancy. The bleeding problems of the first trimester of pregnancy are classified as gynecological so as to stress the important fact that all bleeding patients within the child-bearing age should be considered pregnant until proven otherwise. The discussion will center about measures which are primarily directed toward the control of hemorrhage itself and not necessarily definitive in the ultimate treatment of the basic pathology.

Table 1 represents a schematic outline of the various entities etiologic in the production of hemorrhage in a gynecological patient.  
(Curtis)

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**Presented before the Metropolitan Chapter of the American College of Surgeons, John B. Murphy Memorial Hall, April 19, 1954.**

Table 1

- Group 1. Constitutional and Systemic Causes  
Anemia, nephritis, syphilis, decompensation, cirrhosis, high blood pressure, blood dyscrasias.
- Group 2. Complications of Pregnancies  
Threatening Abortion, Retained Products, Ectopic, Hydatid Mole, Choriocarcinoma.
- Group 3. Benign tumors of the uterus  
Myomas, adenomyosis, endometrial hyperplasia, and polyps.
- Group 4. Malignant tumors of the uterus  
Cervical cancer, endometrial cancer, sarcoma.
- Group 5. Other Causes  
Endometritis, retrodisplacement, Tbc, syphilis.
- Group 6. Tumors and Inflammation of the Ovary  
PID, granulosa cell tumor, malignant tumors.
- Group 7. Functional bleeding.

Bleeding of an alarming amount requiring emergency care is most frequently encountered in Groups 2, 3 and 4. In the other groups, treatment of the underlying pathology will produce a cessation of the bleeding.

Group 2, complications of pregnancy are by far the most common, occurring in the child-bearing age.

In the management of the threatened abortion, hemorrhage of serious proportions usually occurs only when the gestation has separated itself from the uterus and is being expelled, or when the abortion is incomplete. Frequently, speculum visualization of the cervix will demonstrate the gestation in the cervical canal readily amenable to removal with ovum forceps. Supportive therapy with whole blood transfusions will be given

as indicated together with the *judicious use of oxytocics*. Incomplete abortion or retained gestational products calls for therapeutic D & C. together with transfusions and oxytocics as indicated. Ectopic pregnancy represents a distinct challenge to the physician in that diagnosis of the condition may be either clinically apparent on cursory exam or extremely difficult requiring the employment of such diagnostic aids as cul-pocentesis and culpotomy. Concealed hemorrhage from a ruptured ectopic gestation will require supportive therapy with whole blood transfusions if the patient is in a state of shock. In the patient whose hemodynamic picture has stabilized following her initial hemorrhage, the administration of blood may produce a relative hypervolemia which may break loose an occluding clot and produce added blood loss. Therapeutic laparotomy is indicated at the earliest time. The management of hydatid mole is conservative. As a rule, when active bleeding takes place, the uterus is in the process of extruding the mole and supportive therapy with whole blood transfusions and *cautious pitocin* stimulation will be rewarded by a successful outcome. However, in the unusual cases where severe hemorrhage is occurring without progressive commensurate expulsion of molar tissue, operative interference may be indicated. The large size of the uterine cavity under such circumstances usually dictates evacuation by hysterotomy, at which time any invasive characteristics may be demonstrated. The physician is obligated to follow such patients with monthly quantitative AZ tests to demonstrate any retention of molar tissues or malignant degeneration. A persistence or rise in the titre will merit D & C if intercurrent pregnancy can be ruled out. The management of bleeding from choriocarcinoma is usually by hysterectomy and bilateral salpingo-oophorectomy.

Bleeding episodes arising from myomas and adenomyosis (Grp. 3) can frequently be controlled, at least temporarily, with ergot and estrogens, although definitive treatment is with hysterectomy. In dealing with malignant tumors (Grp. 4) particularly cervical lesions, temporary cessation of bleeding can be attained by vaginal packing, especially utilizing the hemostatic cellulose products. A valuable agent in the control and prevention of this type of bleeding is the acetone or formaldehyde pack which toughens

and scleroses the involved tissue. In the event that this fails, extraperitoneal bilateral ligation of the hypogastric, ovarian and funicular arteries is indicated and is usually effective. In Groups 5 and 6, control of hemorrhage will be accomplished through management of the underlying pathology. Group 7, functional bleeding, is not usually thought of as a serious type of bleeding, although it can be alarming in proportions, especially in the pubertal patient. The control of this type of bleeding is supportive, using blood to combat the anemia and large doses of estrogens to eliminate ovarian activity. Once heavy bleeding ceases, general supportive care with anti-anemic therapy, thyroid, estrogens will usually maintain these patients until their overall hormonal balance stabilizes.

Emergency obstetrical conditions, usually encountered in the last trimester of pregnancy can be listed as follows:

1. Placenta previa
2. Abruptio placenta
3. Post-partum hemorrhage
4. Rupture of uterus.

Placenta previa and abruptio placenta, most frequent in occurrence, should be considered together since management can be instituted only when the proper diagnosis has been established. In both of the conditions, severe bleeding is the single outstanding feature, frequently of exsanguinating proportions. As is seen in the chart, it will usually be possible to make a rapid differentiation between the two entities. Placenta previa will frequently have a history of previous spotting or bleeding, toxemia signs and symptoms will be absent as also will pain be absent. On examination, the uterus will usually be soft, non-irritable, not in labor. The picture of shock in both conditions will vary with the amount of blood loss. The bleeding will always be external and on the examination of the cervix, if done, placenta will be palpable. On the other hand, abruptio placenta will not usually be preceded by a history of spotting or bleeding, toxemia signs will be present in 25 to 50% of the cases; pain will always be present. Examination will show a tender, hard, irritable uterus frequently in active labor. The bleeding may be occult, the extent being evidenced only by the relative degree of shock. Examination of

the cervix will show only the presenting part, no placenta.

In the management of placenta previa, once a tentative diagnosis has been made, every effort must be made to replace the blood loss and prepare for further hemorrhage. One of the best hemostatic agents in medicine is a ready-available supply of compatible blood. When the patient is stabilized and fluid or blood is running intravenously, consideration may then be directed toward further definitive treatment in the form of a sterile vaginal examination. This should be done only under a double set-up, where arrangements are ready for immediate caesarean section is indicated. Careful palpation of the lower uterine segment, cervix and cervical os will demonstrate the extent of the previa. The finding of a central previa calls for immediate abdominal delivery. The management of marginalis or lateralis previa will vary with the circumstances. As a rule, conservative measures give better results. Accordingly, the membranes are ruptured, permitting the presenting part to descend and tamponade the bleeding edge of placenta and in most instances, vaginal delivery will follow. If the bleeding is too excessive, or if rupture of the BOW fails to control the blood loss, delivery should be by immediate caesarean section. The use of the Voorhees bag to control hemorrhage in placenta previa is almost universally condemned and the insertion of a vaginal pack, actually of little hemostatic value, is permitted only as a temporary procedure while the preparations are being made for section.

In abruptio placenta, the singular important feature of management is stabilization of the hemodynamic picture.

Very often, occult internal bleeding will cloud the picture and produce a shock state out of keeping with the apparent blood loss. Immediate vigorous blood replacement is necessary. Once a tentative diagnosis has been made and the hemodynamics stabilized, cautious vaginal or rectal examination will indicate the condition of the cervix, an important factor in deciding definitive treatment. As a rule, the conservative, expectant management of abruptio will reward the physician with better results. The irritation of the extravasated blood usually precipitates the patient into a rapid type of labor and vaginal delivery is often accomplished in a surprisingly

short time. At the time of cervical examination, rupture of the membranes serves to enhance the speed of the labor, and the quality of the pains may be further augmented by a cautious pitocin stimulation. As a rule, the onset and progression of labor brings about a cessation of the bleeding; however, the blood picture of the patient must be carefully maintained at a stable level. Caesarean section is indicated in abruptio placenta in those cases where immediate delivery is imperative for fetal salvage, and where the condition of the cervix is such that rapid vaginal delivery cannot be expected.

The most frequent cause of post-partum hemorrhage, usually of emergency significance in the third stage of labor, is uterine atony or inertia. When one realizes that 1500 cc. of blood course through the term gravid uterus every minute, it is understandable how the open vessels of a relaxed uterus can mother a dangerous hemorrhage. It must be remembered that uterine atony is usually preceded by etiologic factors such as prolonged labor, grand multiparity, uterine over-distention with a large infant or twins, so that preparations should be made for this complication even before the patient is delivered. In the face of a hemorrhage of serious proportions, in the third stage, etiology must be accurately and rapidly determined. Visualization of the cervix will rule out a laceration of the cervix or vaginal vault, and an intrauterine exploration will reveal the retained placental cotyledons, the ruptured uterus or the most common atonic uterus. Therapy can be instituted at once. With the intrauterine and abdominal hands, the uterus is massaged to stimulate contractions. An intravenous oxytocic, particularly pitocin, is very valuable in maintaining the uterus in a contracted condition. Bitter experience has prompted the almost universal condemnation of routine packing in the management of 3rd stage bleeding. As a last resort, after all other measures have failed to control the bleeding, hysterectomy may be indicated. Obviously, the patient's general condition must be continually maintained with transfusions and supportive therapy as indicated.

Time will not permit a didactic discussion of the diagnosis of rupture of the uterus. May it suffice to say that the presence of bleeding and/or shock in association with an operative de-

livery, caesarean section scar, the 3rd stage of labor or associated with a prolonged, neglected labor, should call to mind the potential diagnosis of uterine rupture. Examination will usually elicit a rent in the uterus. The treatment in itself is well standardized, i.e., hysterectomy, but of cardinal importance is the stabilization of the patient's hemodynamic picture prior to surgery. Immediate blood replacement is imperative. At times, it may be convenient and feasible to

clamp the uterine arteries vaginally so as to effect a temporary cessation of exsanguinating hemorrhage while preparations are made for immediate surgery. This is accomplished with long clamps after first elevating the bladder and ureters off the anterior surface of the cervix to avoid a crushing injury. The total hysterectomy is preferred over the subtotal.

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## WHAT IS AN ALCOHOLIC?

Let us first consider all the wrong definitions of an alcoholic. Everyone has heard the expression, "An alcoholic is an individual who drinks alone." Many a father and mother have given advice to their offspring sounding like this: "Son, never drink alone, and you will never be an alcoholic." Also, many well meaning doctors, psychiatrists, and clergymen have given the same advice. However, the fact is that there are many, many alcoholics who never drink alone. As soon as they start drinking they become gregarious and develop "telephonitis." They do not want to be alone — they want to be with others.

There is another axiom: "The alcoholic is the person who has to take a drink in the morning." Then, as a corollary, this advice is given: "If you don't drink in the morning, you are not an alcoholic." There are many alcoholics laboring under this misinformation. Think of those who refuse to consider themselves alcoholics because

they fight off the jitters all morning with aspirin, BC, and Bromo Seltzer, until at 12 noon they resume their drinking. Another common error regarding alcoholism is the recommendation, "Never drink every day and you'll not be an alcoholic." We are all familiar with the "periodic binge" type of drinker who may go for weeks, months, or even years without touching a drop and then go on a real spree. It makes no difference whether an alcoholic is a periodic drunkard or a drunkard, period.

What then is alcoholism and who is the alcoholic? Alcoholism is a symptom — yes, a symptom of an underlying illness. An alcoholic is an over-the-line drinker whose drinking interferes with his everyday living. He is one who, having taken one drink, cannot guarantee his behavior. He is a person who, after taking the first drink, cannot tell when he is going to stop. *George A Constant, M.D., Alcoholism — A Public Health Problem. Texas J. Med. March 1954.*

# PATHOLOGY CONFERENCES

EDWIN F. HIRSCH, DEPARTMENT EDITOR



## Complications with Old Infarcts of the Heart

Edwin F. Hirsch  
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- 1—Anemic atrophy of the myocardium;
- 2—Focal aneurysm of the left ventricle with rupture;

- 3—Saccular aneurysm of the lateral wall of the left ventricle;
- 4—Saccular aneurysm of the inter-ventricular septum

### **1 — ANEMIC ATROPHY OF THE MYOCARDIUM**

A negress aged 52 years entered St. Luke's Hospital on September 11, 1948 in the care of Doctor G. K. Fenn. In 1929 a bilateral salpingophorectomy and subtotal hysterectomy had been done for chronic salpingitis. She returned on July 10, 1948 because of shortness of breath for about two years, weakness of the right arm and leg and double vision for 2 days. The weakness and double vision appeared suddenly and were associated with precordial pain, coughing and marked shortness of breath. Her blood pressure then was 112/80 mms. Hg., the pulse was 110

and the respirations 18 per minute, and her temperature was 100°F. The heart was markedly enlarged to the right and to the left. There were subjective diplopia and rales in both lungs. The electrocardiogram demonstrated sinus tachycardia, a left bundle branch block and delayed A-V conduction. The blood was slightly anemic, the urine contained 75 mgms percent albumin. Her condition improved and she was discharged, July 28, 1948. She re-entered the hospital on August 29, 1948 complaining of a productive cough, and a sudden pain in the chest. A roentgen film demonstrated marked cardiac enlargement and vascular congestion of the lungs. The electrocardiogram was essentially the same, and



**Figure 1. Photograph illustrating the fibrous thickening of the lining and dilatation of the lumen of the**

**left ventricle. Note the atrophic flat papillary muscles.**

clinically she was thought to have had pulmonary embolism. She was discharged, September 7, 1948, but returned on September 11, 1948 because of weakness, a productive cough, shortness of breath and substernal constriction with coughing.

She appeared ill, had a blood pressure of 114/80 mms. Hg., a pulse of 132 and respirations 32 per minute. The heart was enlarged, there were no murmurs, but frequent extrasystoles. The liver was palpable at the umbilicus. The blood was slightly anemic, the urine had 100 mgms percent albumin, and the electrocardiogram showed a sinus rhythm, a partial A-V block, and a left bundle branch block. A roentgenogram disclosed an enlarged heart. On the third hospital day she had an attack regarded as pulmonary embolism. She died suddenly on October 4, 1948.

The essentials of the anatomic diagnosis of the necropsy (trunk) are:

Chronic fibrous myocarditis, dilated chambers, marked atrophy of the papillary muscles, old fibrous endocarditis, and mural thrombosis of the left ventricle of the heart;

The right pleural space was obliterated by fibrous adhesions, the left side had none and contained a small quantity of fluid. The pericardial

sac had the usual clear limpid yellow fluid and anteriorly were adhesions between the parietal and visceral surfaces. The large heart weighed 620 gms. All of the chambers were dilated. The lining of the right side of the heart was smooth, the tricuspid leaflets had slight fibrous changes. The lining of the left auricle and auricular appendage was smooth. The lining of the dilated left ventricle (Figure 1) was gray with fibrous tissue, portions in plaques. The papillary muscles were flattened and atrophic. The mitral ring was dilated (10.5 cms. circumference). The myocardium of the left ventricle measured along the septum behind was 2 cms. thick at the mitral ring level but diminished to 1 cm. at the apex. The muscle tissues had multiple fibrous scars. The lining of the coronary arteries had fibrous and fatty changes but no focal occlusion. The aorta had a moderate atherosclerosis. The changes in the viscera otherwise were essentially those of passive hyperemia and edema. There was no evidence of pulmonary embolism.

## **2 — FOCAL ANEURYSM OF THE LEFT VENTRICLE WITH RUPTURE**

This white male aged 46 years entered St. Luke's Hospital on February 20, 1952 in the

care of Doctor Fred Ball and died on March 22, 1952. When admitted had had a severe pain in the upper part of the left chest, shoulder and throat for about one and a half hours associated with cold sweat, dizziness and finally syncope. He had had a similar less severe attack ten days previously in French Morocco, just before leaving for home. The pain had persisted while enroute by plane but gradually decreased. He had been stationed in Africa for eight months but had had no attacks of this kind although he had had several attacks of dysentery.

When admitted he was a well nourished adult white male in profound shock, conscious and alert. His blood pressure was 50/40 mm. Hg and his temperature was 100.4°F. The pulse was thready and barely perceptible, 108 per minute and the Cheyne-Stokes respirations were 16 per minute. The extremities were cold. The lungs were clear, the heart not enlarged to percussion but the heart tones were distant, regular in rhythm and force and without murmurs. There were no other significant physical findings.

The erythrocytes were 4,000,000 per c. mm., the hemoglobin was 12.2 gm. percent and the leukocytes 21,500 per c. mm. with 67 percent polymorphonuclear cells. The urine contained 80 mgm percent albumin, but no sugar. The sedimentation rate was increased. Serological tests of the blood were negative. The non protein nitrogen of the blood was 33 mgms and the sugar 159 mgms percent. The electrocardiogram had changes consistent with an antero-lateral infarct of the myocardium.

He received oxygen therapy, morphine and atropine sulphate, aminophyllin and anticoagulants. Later when removed from the oxygen tent he had an attack of auricular fibrillation. Oxygen therapy and digitoxin relieved this cardiac disorder. He seemed to make a remarkable recovery when a precordial friction rub developed and about 24 hours later he became cyanotic, had labored respiration and an imperceptible pulse. He failed to respond to emergency therapy and died.

The essentials of the anatomic diagnosis of the necropsy (trunk) are:

Spontaneous rupture and mural thrombosis of

an aneurysmal infarct of the left ventricle of the heart;

Huge hemopericardium;

Obturator thrombosis of the ramus circumflex of the left coronary artery;

Marked atherosclerosis of the coronary arteries;

The pericardial sac contained 700 gms. (about 650 ccs) of firmly clotted blood. The heart was large and weighed 560 gms. In the lateral wall of the left ventricle 8.5 cms. above the apex was a thin walled collapsed saccular aneurysm 2.5 by 3 cms. in dia. with an irregular crescent shaped laceration across the center 1 cm. long and with torn edges gaping 0.5 cm. (Figure 2.) A small mural thrombus was attached to the lining. The pouch was behind the posterior papillary muscle. The lining and valve structures on the right side of the heart had no changes. The leaflets of the mitral and aortic valves were thin but the cavum of the left ventricle was dilated. The myocardium of the left ventricle along the septum behind was 1.2 to 2 cms. thick. The lining of the coronary arteries had marked fatty and fibrous changes and focal atheromatous plaques. An anterior descending branch of the ramus circumflex of the left coronary artery extended to the edge of the

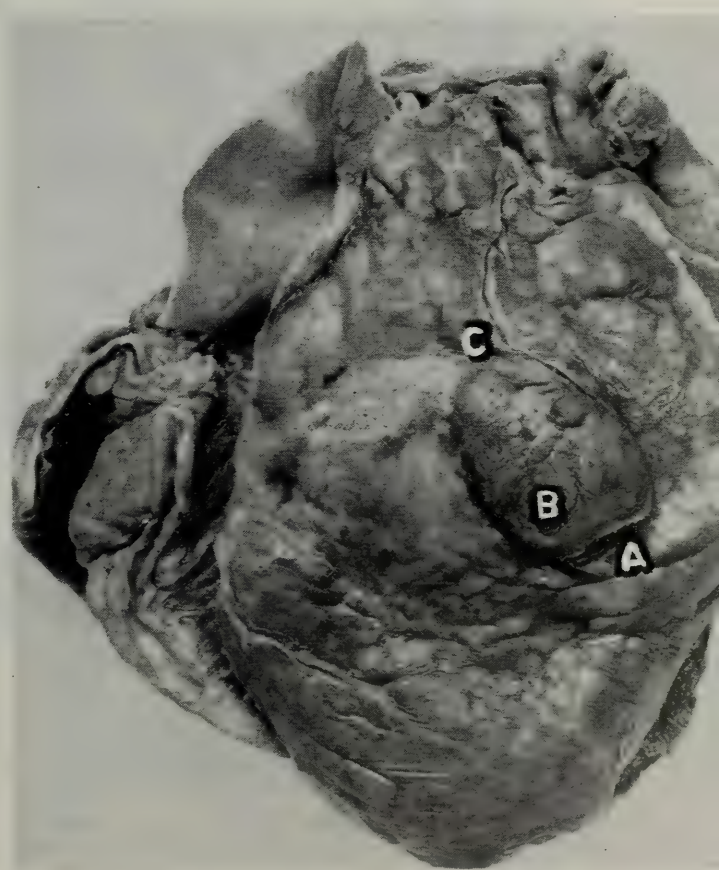


Figure 2. Photograph illustrating the ruptured aneurysm of the left ventricle of the heart. — (A) rupture; (B) aneurysm; (C) stenotic branch of the coronary artery.

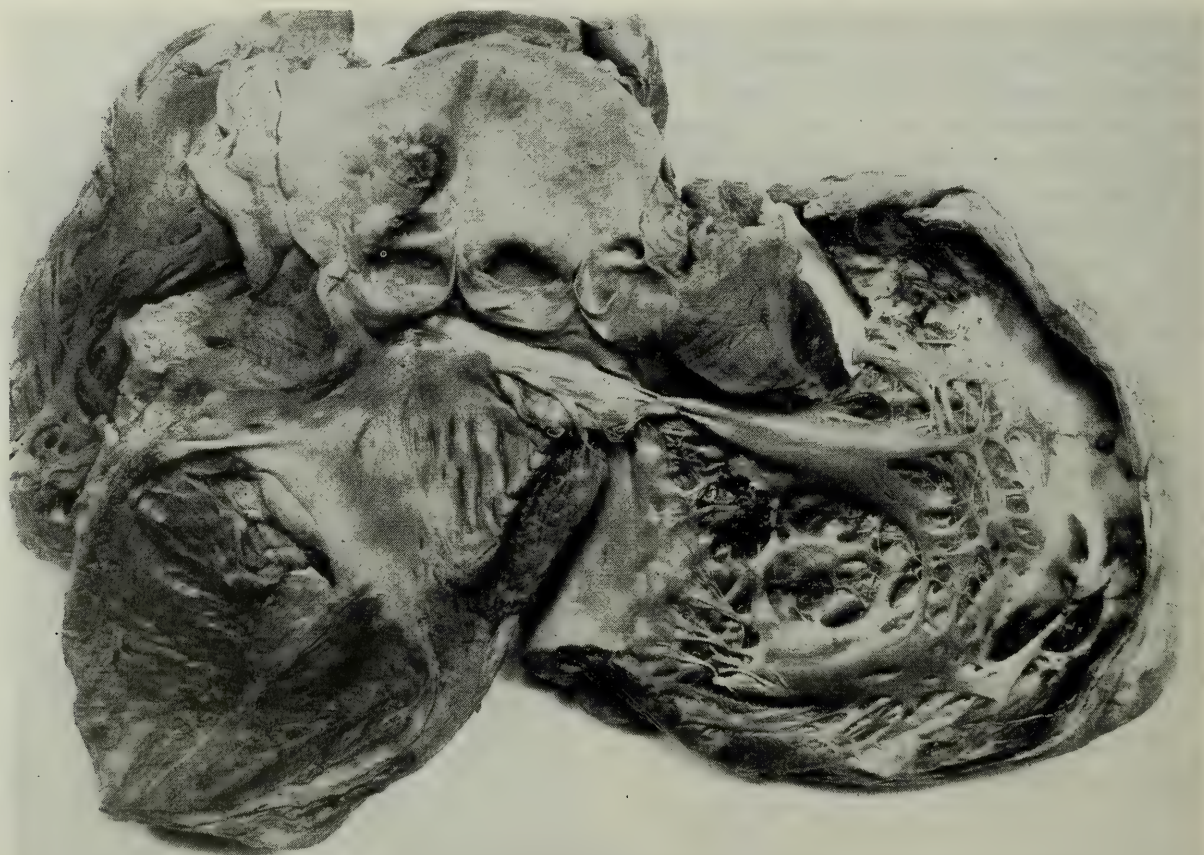
aneurysmal sac. The lumen of the distal 2 cms. of the vessel was markedly constricted by a calcified fibrous atheroma and occluded by a small red thrombus. The right coronary artery 10 cms. from its origin had a markedly narrowed lumen. There was a marked edema of the lungs, the right weighing 640, the left 500 gms.; otherwise the viscera had no significant changes.

### **3 — SACCULAR ANEURYSM OF THE LATERAL WALL OF THE LEFT VENTRICLE**

A white male aged 57 years entered St. Luke's Hospital in the care of Doctor R. Roskelley on November 7, 1952 and died on December 11, 1952. Twenty-five years before he had had a partial thyroidectomy for hyperthyroidism. In 1949 and again in 1950 similar symptoms were controlled by drugs. He entered the hospital in August 1952 because of severe attacks of substernal pain and the diagnosis of myocardial infarction was supported by electrocardiograms. After 24 days in the hospital he was discharged,

but on November 6, 1952 he again had severe pain in the left side of his chest, shoulder, neck and arm. When admitted to the hospital his temperature was normal, his pulse 84 per minute and his blood pressure 80/60 mms. Hg. The heart was enlarged, the sounds distant and poor in quality. There were many extrasystoles. The blood had 4,000,000 erythrocytes and 12,100 leukocytes per c.mm. The serum cholesterol was 323 mgms percent. The other chemical constituents were not unusual. The urine had 30 mgms percent albumin. Electrocardiograms demonstrated auricular fibrillation, ectopic ventricular systoles and evidence of myocardial infarction. Roentgenograms of the chest revealed a markedly enlarged heart and right pleural effusion. On November 12, 1952 a friction rub was heard over the apex of the heart. His condition grew worse, he became markedly dyspneic and died on December 11, 1952 with the clinical diagnosis of myocardial infarction.

The essentials of the anatomic diagnosis of the necropsy (trunk) are:



**Figure 3. Photograph illustrating the saccular aneurysm of the lateral wall of the left ventricle of the heart and the marked atrophy and fibrous replacement of**

**the myocardium. Note the large mural thrombus on the septum.**



**Figure 4. Photograph illustrating the marked ulcerated atherosclerosis and mural thrombosis of the aorta.**

Extensive old fibrous infarct of the lateral wall and septum of the left ventricle of the heart with mural thrombosis of a large aneurysmal dilatation;

Marked constricting atherosclerosis of the coronary arteries of the heart;

Obliterative fibrous and fibrinous pericarditis;

Dilated chambers of the heart;

Marked ulcerated and calcified atherosclerosis of the aorta;

Etc.

Both lungs were moderately compressed; the right pleural space contained about 700 cc. of a clear amber fluid, the left about 150 cc. The pericardial sac was obliterated by fibrous and

fibrinous adhesions. The heart weighed 650 gms. The chambers were dilated, especially the left. The lining of the right chambers had small focal fibrous thickenings. There were similar thickenings of the left auricle and auricular appendage. The lining of the lower portion of the dilated left ventricle was thickened by fibrous tissue especially the septum and apex. The lower portion of the left ventricle had an aneurysmal dilatation (Figure 3) and the wall here was reduced to 4 mms. thickness. The aneurysm involved the septum and the lining here was covered with a firm red brown mural thrombus. Portions of the septum toward the base of the heart had a recent infarct. The lumen of both coronary arteries was markedly narrowed, especially the proximal portions and the lung had a marked atherosclerosis. The aorta had a marked ulcerated and calcified atherosclerosis with mural thrombosis (Figure 4). The changes in the viscera otherwise were mainly those of a chronic passive hyperemia.

#### **4 — SACCULAR ANEURYSM OF THE INTERVENTRICULAR SEPTUM**

A white male aged 58 years entered St. Luke's Hospital on March 5, 1953 in the care of Doctor G. K. Fenn. Two weeks before he had had an attack of pain in his chest and had been at rest in bed for three days. Just before admission he had nocturnal dyspnea. When admitted his temperature was 101°F., his pulse 120 and his respirations 24 per minute. The heart tones were distant and his liver extended 5 cms. below the right costal border. The blood had a slight anemia and 11,800 leukocytes per c.mm. The urine had no significant changes. A roentgenogram demonstrated an enlarged heart. Electrocardiograms indicated a possible anterior myocardial infarct. The patient was given sedatives, anticoagulants, and oxygen but he had frequent attacks of dyspnoea and died during one of these on April 24, 1953.

The main portions of the anatomical diagnosis of the necropsy (trunk) are:

Extensive old fibrous infarct with saccular aneurysm and mural thrombosis of the septal myocardium of the left ventricle of the heart;

Marked dilatation of the left ventricle of the heart;

Marked atherosclerosis of the aorta and of its main branches;



**Figure 5. Photograph illustrating the large saccular aneurysm of the septum with mural thrombosis of the**

**left ventricle of the heart.**

Saccular aneurysms of the abdominal aorta, the right common iliac artery, and of the right coronary artery;

Chronic obliterative fibrous pericarditis.

The heart weighed with some adherent pericardial sac 890 gms. The chambers on the right side were dilated. The lining of the left auricle, auricular appendage and left ventricle had fibrous thickenings, especially the left ventricle toward the apex. The chamber of the left ventricle was markedly dilated into an aneurysmal structure and the myocardium at the apex was replaced by fibrous tissues. The septum formed part of the aneurysm and in the sacculation here was a large dark red mural thrombus 10 by 8 cms. (Figure 5). The wall was thin. The lining of the coronary arteries had moderate fatty and fibrous changes. The right coronary artery had a dilated lumen and at 1 cm. and 2.5 cms. levels from its origin were saccular aneurysms 1 cm. in dia., the one distally with a subintimal hemorrhage (Figure 6). The aorta had marked athero-



**Figure 6. Photograph illustrating the saccular aneurysm (A and B) of the right coronary artery.**

sclerosis, (Figure 7), the abdominal portion had an aneurysm 10 cms. long and 2.5 cms. in circumference. The right common iliac artery also had a saccular aneurysm 2.5 cms. in dia. The viscera of the body otherwise had a marked chronic passive hyperemia. In the region of the right suprarenal gland was a mass of soft gray tissue 7 by 5.5 by 3.5 cms. weighing 45 gms. and with the structure of seminoma tissues. No tumor tissues were found in the testes by gross or microscopic examinations. The periaortic abdominal lymph nodes had metastases of similar tumor tissues.

#### COMMENT

These four records and descriptions illustrate late complications of myocardial infarction. The first exemplifies interference with coronary circulation below the level adequate for functional needs. Accordingly there is a marked atrophy of the muscle fibers, especially obvious in the papillary muscles and columnae carnae which become flat bands. The other records describe the formation of aneurysms as a complication; Case II a small focal lesion with rupture, Cases III and IV, aneurysmal dilatation of the lateral wall and of the septum. Mural thrombi in these become the source of emboli carried into the systemic circulation.



**Figure 7. Photograph illustrating the marked atherosclerosis of the aorta, and the saccular aneurysms of the abdominal aorta (A) and the iliac arteries (B and C). Note the metastatic seminoma-like tissues in the lymph nodes along the aortic aneurysm.**

## EDITORIALS



### THE CURE OF GRIEF

Mantacinni was one of the most notorious quacks in history. His most daring deed occurred in a village where he boldly predicted that on a certain day he would revive all those who had died within the preceding 10 years. As the day of resurrection drew closer, his servant became more nervous about the outcome. But Mantacinni assured him, "You don't know mankind. Wait and see."

Then he received a letter which said, "Sir: The great operation which you are going to perform has broken my rest. I have a wife buried for some time now who was a fury and I am unhappy enough without her resurrection. For heaven's sake, do not make the experiment."

This was followed by a stream of letters and secret visitors. Before the day of the miracle, the hamlet was in a state of excitement and confusion. Mantacinni, according to C. J. S. Thompson, the medical historian, was escorted out of town but his pockets were well lined with gold.

The late Dr. Thomas N. Horan<sup>1</sup> used this story as an exaggerated example of the short span of grief for the departed held by some individuals. Much has been written on the phenomenon but little research has been conducted on the cure. Thomas Elliot pioneered in this

field by collecting data from bereaved persons or their families. What kind of adjustment did they make? The successful obtained cure through the substitution of a new love object, a thoroughgoing religious rationalization, devotion to life work, or the creation of constructive memorials.

Partial relief was obtained through resignation, stereotyped formulae of immortality, and sentimental memorials. Extreme loneliness was considered partial failure and suicide and insanity resulted from complete failure.

Horan was able to find additional information on the cure of grief. Job was comforted when he submitted to the laws of God. The Greeks and Romans philosophied: "If thou has full governance of thyself, thou wouldst have something within thee which misfortune could not wrest from thee."

Plutarch wrote his wife on the death of their 2 year old daughter: "I would have you endeavor to call often to mind that time when our daughter was not yet born to us, and when we had no cause to complain of fortune. Then, joining that time with this, argue thus with yourself, that we are now in the same condition as then. Otherwise, dear wife, we shall seem discontented at the birth of our little daughter, if we own that our circumstances were better before her birth. But the two years of her life are by no means to be forgotten by us, but to be num-

<sup>1</sup>Harper Hosp. Bull. 12:118 (May-June 1954). ON TEARS AND GRIEF, presented before the Detroit Medical Society in 1938 by the late Thomas N. Horan, M.D.

bered amongst our blessings, in that they afforded us an agreeable pleasure."

When David lost his son he said, "I shall go to him but he shall not return to me." Osler is quoted as saying, "I whistle that I may not weep."

Many of our best thinkers throughout the ages thought alike in their attitude toward old age and death. "Death is either like sleep, a truly agreeable state free from trouble and pain, or the beginning of a new life full of variety, new tasks, greater understanding." The list of attractions of old age includes pleasures of recollection and re-evaluation.

Horan added his own remedies for those in sorrow:

"To the voluptuary of grief, we offer widow's weeds and latticed blinds, slightly open. To the passive and resigned, Isaiah's promise—God shall wipe away all tears from their eyes. To the worker, like Madame Curie—to yours from falling hands we throw the torch. To the deeply religious—he that believest in me, though he were dead, yet shall he live. Concerning the old, the words of the nunc dimittis—Lord, now lettest Thou thy servant depart in peace, according to thy word. And to all who mourn an untimely death, the pagan story of the afterworld where all is beauty and joy, except a small number who are weeping. They are the dead who weep for the living."

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## BEAUMONT MEMORIAL

On July 17, 1954, by invitation of the Michigan State Medical Society, I attended the dedication ceremonies of the Beaumont Memorial at beautiful Mackinac Island. The property was purchased and the building restored by the Michigan State Medical Society and was given in a colorful ceremony to the Mackinac Island State Park Commission to be preserved by the State of Michigan as the country's most significant medical shrine.

The Memorial was built and furnished in authentic style through individual contributions from the physicians of the State of Michigan. Dr. Otto O. Beck of Birmingham, Michigan, chairman of the Beaumont Memorial Committee, adopted the Beaumont Memorial as a major project during his term as president of the Michigan State Medical Society in 1951-52, just prior to

the hundredth anniversary of Dr. Beaumont's death in 1953.

It is a reconstruction of the original American Fur Company Store, adjacent to old Fort Michilimackinac, where the hardy young French-Canadian voyageur Alexis St. Martin on the evening of June 6, 1822, was gravely wounded in the left upper abdomen by the full accidental discharge of a shotgun not over three feet away.

The stone-walled French habitant-type cottage, which rests on the original site's foundation, contains two main rooms of which the larger is the Beaumont Memorial Room containing Dean Cornwell's well known painting of Dr. Beaumont ministering to his patient, Keller's portrait of Dr. Beaumont, some crude but effective instruments, such as an amputation knife and saw, and other relics of historic interest.

William Beaumont was born at Lebanon, Connecticut, on November 21, 1785. He attended public school there and at the turn of the century, when he was 15, Thomas Jefferson had succeeded to the presidency. Beaumont left his father's home in 1806 traveling with a horse and cutter, a barrel of cider and \$100. In the spring of 1807 he arrived at the little village of Champlain, N.Y., where he taught school for three years.

On his way to Champlain he came in contact with Dr. John Pomeroy, a prominent physician and surgeon of Burlington, Vermont, who loaned him medical books, which he diligently read while teaching school in Champlain.

In the fall of 1810, he began a two year apprenticeship with Dr. Benjamin Chandler of St. Albans, Vermont, a very fine practitioner who exerted an excellent influence upon the young physician which was manifested in his later medical life.

Dr. Beaumont never attended medical school. He had no chemistry, little physiology, and no knowledge of research. However, on June 2, 1812, he was given a license to practice medicine. His diploma was signed by Dr. Pomeroy, his former benefactor.

He joined the U.S. Army as a surgeon's mate on Sept. 13, 1812, and received his commission issued by President James Madison in Dec. 1812. In 1815 he resigned his commission and engaged in private practice until 1819, when he again entered the army and on March 18, 1820, was

commissioned Post Surgeon of the U.S. Army by President James Monroe. He was immediately ordered to Fort Mackinac on the northern frontier, which, two years later, was to become the scene of his momentous research on the physiology of digestion and his acceptance as a scientist.

Through the opening in Alexis St. Martin's stomach, Dr. Beaumont was the first to study the physiology of digestion in a living human. It was more than 60 years before any significant discoveries were added to his observations and experiments. His findings remain the foundation for current knowledge of the physiology of the stomach.

In 1824 Dr. Beaumont sent a complete report of his research on the stomach of St. Martin to the Surgeon General of the Army for his approval and correction, and suggested that it be published in a reputable medical journal. The article appeared in the *Medical Recorder* in 1825 and was published as "A Case of Wounded Stomach" by James Lowell, Surgeon General, U.S.A. The mistake in the name of the author was corrected and credit given to Beaumont. In 1833 the experiments were published in detail.

Alexis St. Martin was the father of several children and outlived Dr. Beaumont by several years. Dr. Beaumont practiced medicine the last 20 years of his life in St. Louis, Mo., where he died in 1853.

Dr. Beaumont was elected an honorary member of the Michigan Territorial Medical Society — forerunner of today's Michigan State Medical Society — in June, 1825, soon after the first accounts of his experiments had been published.

In 1900 the Upper Peninsula Medical Society, in co-operation with the Michigan State Medical Society, erected a stone monument on Mackinac Island in memory of Dr. Beaumont. Each year since 1922 the Wayne County Medical Society has presented a Beaumont Lecture and a Scientific Lecture in his name and is now a feature at each annual session of the Michigan State Medical Society.

In accepting the Memorial to Dr. Beaumont, Michigan has honored a man who typifies in several ways the traditional high standards of the medical profession in America. Dr. Beaumont, in various stages of his life, was representative of the devoted medical practitioner, the tire-

less research worker, the heroic army doctor, and, in his later years, the skillful medical teacher. Congratulations to the Michigan State Medical Society for a job well done!

Arkell M. Vaughn, M.D.

1180 E. 63rd Street

Chicago, Illinois

Credit due for information to:

L. W. Hull, M.D.,

President, Michigan State Medical Society

Otto O. Beck, M.D.,

Chairman of Beaumont Memorial Committee

Alfred H. Whittaker

former Committee Chairman of Beaumont Memorial Committee

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## **MEDICINE FROM 1850-1900 — A VIEW OF OUR MEDICAL BACKGROUND**

Addison described pernicious anemia and suprarenal disease in 1849. The germ theory had not yet been born. Helmholtz invented the ophthalmoscope in 1851. The hypodermic syringe was introduced by Pravaz in 1852. The clinical thermometer was seldom used until after 1870. Drs. Keen and Tyson of Philadelphia served during the 1862-65 period of the Civil War and neither used a thermometer or a hypodermic syringe while in the service.

No one should live entirely in the past. But a total lack of interest in what has happened in years gone by often indicates that one has nothing but a selfish interest in the present, and cares little about what may happen in the future. And what can be more deadly than a lack of interest in the future of one's profession, or one's country.

In order to give those of us who are living today, and the physicians who follow us, a better understanding of what has happened in our medical past, the Illinois State Medical Society in 1927 published Volume I of the History of Medical Practice in Illinois. This Volume described medical practice in Illinois from the post Revolutionary War period until 1850. The Committee on Medical History of the State Medical Society has now completed Volume No. II showing the progress in medicine between 1850 and 1900. Amazing discoveries were made during this half century and were promptly put to use by the Illinois physicians of this

period. These discoveries paved the way for medical practice as we know it today. To properly appreciate our progress since 1850 every physician in Illinois should have and read Volume No. II. In addition to describing general practice during this era, it provides a history of the development and progress of all of our specialties since 1850, and there were very few specialists before that time. Descriptions of medical education and histories of medical schools, histories of independent medical societies, medical libraries in the State, medical journalism, nursing, medical geography, and many other topics of interest to physicians are competently presented by leaders in each field.

Tom Kirkwood, M.D.,

Chairman, Committee on Archives

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## LEGAL MEDICINE — THE NEW APPROACH\*

A grave misconception now current in the medical profession at large, and more particularly among pathologists, is that the Medical Examiner System is designed for the express purpose of replacing, in all jurisdictions, the old coroner system.

The coroner's jurisdiction is always predicated on the probability or possibility of foul play. The modern progression of knowledge and methodology has rendered the office of coroner obsolete. Indeed, if the medical problems dealing solely with those of foul play were the only ones concerned, it is questionable whether it would be practical to set up a system of trained personnel for the relatively few obscure cases of violent death that require expert medical review.

The modern medical examiner is not concerned primarily with the medical fact-finding functions of the old coroner. What must be recognized is that because of the vast social and economic advances that have been made, it has become necessary for the State to establish a new officer whose function it is to inquire into a great variety of deaths; the vast majority of these are not associated with foul play. It is essential for the State to provide a system for deciding whether on purely medical grounds a decedent's

family has a claim against private funds, i.e., funds held by the insurance companies in trust for their policy holders. As a corollary, it is necessary to decide whether both State and private funds are to be protected against raiding by claimants.

It is important to ascertain whether decedents, who have died from obscure causes, have in fact died from infections or contagious diseases that constitute a menace to the public health. It is important that a large number of deaths be investigated to ascertain trends of disease in order that Society may take the proper steps to solve problems associated with such diseases. Moreover, it becomes increasingly important to Society to know precisely the cause of death, certainly in obscure situations, and ideally in every case in order that a clear picture of the deficiencies in the Nation's health be adequately known and studied.

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## MEDICINE IN THE NEWS\*

Herewith we point the long accusative editorial finger at an unlovely sequence in modern medical publication. Schering's interesting and illuminating publication, whose caption is the title of this commentary, becomes the focal point of our argument. Scanning through this brochure, which is a helpful physician's service by the Department of Public Relations of the Schering Corporation, we are at once struck with the consistent nature of the sort of things which are being copied from the medical literature for lay consumption. Out of 31 medical subjects discussed in the lay press in April and May of 1954, only 11 (33 per cent) are free of a strong commercial pharmaceutical trend. Fourteen of these papers are definite plugs for new, and many of them unproved, proprietaries. Five of them are pointed toward the use of pharamaceuticals which are chiefly name brand products (the same thing by strong inference). Here we have, then 19 out of 31 subjects chosen for transmission to the lay reader which are nothing in the world but indirect pharmaceutical advertising.

The degree to which the laity is prejudiced in favor of these medications by these complicated technics is dependent to a certain degree

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\*Geoffrey T. Mann. Program International Congress of Clinical Pathology, International Conference of Geographic Pathology, and International Meeting of International Association of Medical Museums, September 6-11, 1954, Washington, D.C. page 96.

Am. J. Cl. Path. 24:(Aug.) 1954.

\*Western Journal of Surgery, Gynecology and Obstetrics (abbreviated to West. J. 62:6 (June) 1954 p. viii

upon the style of presentation. In this respect, it is of note that not a single one of these reports is negative or even skeptical in relation to the merits of the product. They are all absolutely pro, and mostly without any qualification or reference to dangers or side reactions. There is certainly something a little unreal in the total picture if not, by necessity, in each separate offering.

Some years ago this commentator got into a fine kettle of hot water by publishing a precise analysis of the percentage of papers appearing in the higher brackets of current medical journals, which were devoted to the positive interest of pharmaceuticals. Figures which are documented are briefly as follows: In a given period, selected at random, 12 per cent of the papers in the three most prominent obstetrical and gynecological journals were devoted to reports on proprietaries. Of these, 90 per cent were described as highly beneficial, nine per cent as noncommittal or open to a later decision, and only one per cent as unsatisfactory. This as opposed to what we are now designating, was material appearing strictly in topnotch journals of our specialty. Since that time, in our opinion, the total situation has deteriorated.

This practice in medical journals seemed sufficiently unhealthy at the time the above mentioned commentary was made. However, at that time the third side had not developed to complete the unwholesome triange of: (1) unproved claims for pharmaceuticals; (2) publication of weak documentation in medical journals; and (3) propagandizing of these preliminary reports by the lay press. Only in the last few years has this shabby isosceles achieved its complete outline and its truly alarming proportions. It is high time that it be clearly designated.

Medical advertising, per se, in recent years has done a magnificent job of housecleaning, but the growth of this oblique type of advertising by inference and influence, you may say, is serving to defeat much of the good which has been done. Journal advertising direct to the laity of medical and surgical items is in some respects a less unhealthy practice because it is at least in the open, and can be qualified for what it is. On the other hand, the subtle approach which selects some of the more vulnerable morsels from scientific publications and presents them in the glamorous light of popular current literature, is

indeed insidious. It will take the reading public a long time to label these sequences by their proper adjectives.

The most important aspect of this entire sequence is that the fault lies basically with ourselves. The original material, much of it as it appears in the medical literature, is not sufficiently documented, nor is it in any sense prepared or suitable for lay consumption. One of the reasons medical journals publish these preliminary reports is to open them to the arguments and the application of proper controls. Lay readers are in no position to understand this. The fact is, that as stated in medical publications and as understood by physicians with critical intelligence, such material is to a certain extent justifiable. As quoted, however, by publicity minded ghost writers to the laity, it is quite another business. The ghost writer and the feature writer for the public are apt to capitalize specifically on the weak points of the scientific thesis. In spite of these considerations, which are obvious to physicians, we will do better to screen our preliminary scientific reports more carefully than we have in the past. This is the only influence which we as physicians can exert to break up this unholy triple alliance. Speaking for this journal — we are getting busy in this respect. G. C. S.

## ENCOURAGING STATISTICS

An interesting report was recently released by the Institute of Life Insurance showing that persons who survive a cancer operation by several years have an encouraging life expectancy. The study was made from statistics reviewed critically by the Society of Actuaries. A careful study was made of 725,000 policies covering persons with some known physical impairment, carrying through a 15 year period. Included in this study were policies on about 1,000 persons who had been operated on for cancer five years or more prior to the issuance of the policies.

Some of these people had been accepted as standard risks without extra premium and their mortality experienced was practically the same as the standard risks. Those accepted at an increased premium rate showed a death rate about twice that for the standard group, the excess mortality being due to a recurrence of cancer. The study did not show any tendency for the disease to be hereditary, following a careful study

of those persons reporting a family history of cancer in any site.

Tuberculosis experience was also critically studied by the group of actuaries. In cases of persons with a history of pulmonary tuberculosis and underweight at the time the policies were issued, there was no adverse effect on mortality rates. It had been previously felt that underweight was a distinct hazard in connection with tuberculosis history. Among cases where the tuberculosis history was ten or more years prior to the issuance of the policies, the death rate for selected cases with a minimum lung involvement was about normal for those accepted at standard rates, and only slightly above normal for those accepted at extra-risk rates. Where the tuberculosis history was 6 to 10 years prior to application, the death rate was normal for standard risks and slightly increased for those who were extra-risk cases. Among those accepted with a three to five year history, showed a death rate

about twice that of the standard. The mortality among persons with a history of chronic bronchitis was unfavorable, being about twice the normal.

This study is said to have been the most comprehensive of any previously made as it covered 132 groups of physical impairments and medical histories, further subdivided into 388 classifications. This interesting report when compared with one made 25 years previously shows that longevity had increased materially for persons with most impairments. The mortality among such persons has decreased in about the same proportion as that among standard risk during the past 15 years.

This report reflects much credit upon medical men and medical progress in recent years. It likewise should materially improve the morale of many who have an early diagnosis of many serious conditions which may be alleviated permanently by the early institution of the proper treatment.

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## THE MECHANICAL HEART

Every mechanical heart-lung apparatus devised to take over temporarily the entire functions of the heart and lungs must comprise four essential features. First, there must be a good method of pumping blood through the circuit which does not cause hemolysis, which can be quickly and easily adjusted to varying flow rates, and which enables the blood circuit to be easily and thoroughly mechanically clean. Second, the mechanical lung must not only fully saturate the blood with oxygen but must maintain the carbon dioxide tension of the blood at a normal level. The latter requirement may be taken care of by an automatic apparatus which continuously reads the pH of the blood leaving the mechanical lung and adjust the carbon dioxide tension accordingly. Third, the apparatus must hold a constant

amount of blood at all rates of blood flow. This can be accomplished by electronic control of the pumps removing blood from plastic chambers so that the pumps operate always to maintain a constant level of blood in the reservoirs at the bottom of the chambers. The thickness of the blood film on the screens in the oxygenator is kept constant by an extra pump which always circulates a constant flow of blood over the screens. Fourth, such an apparatus must be able to remove smoothly all the venous blood returning to the heart through the venae cavae without collapsing these veins. We have found the simplest way of accomplishing this is to interpose a negative pressure chamber between the pump and the cannulae in the venae cavae. *John H. Gibbon, Jr., M.D. Application of a Mechanical Heart and Lung Apparatus to Cardiac Surgery. Minnesota Med. March, 1954.*

# MEDICAL ECONOMICS

**The Medical Economics Committee. John R. Wolff, Chairman, Walter C. Bornemeier, Edward W. Cannady, Roland R. Cross, Jr., E. F. Dietrich, W. W. Fullerton, Edwin F. Hirsch, Frederic T. Jung, W. R. Malony, Caesar Portes, William Requarth, Frederick W. Slobe.**



## Ethics and Economics

**Walter C. Bornemeier, M.D.  
Chicago**

The July 17, 1954, Journal of the American Medical Association carries the report of the final verdict in the three year controversy over the Code of Ethics in regard to billing procedures, division of fees and definition of fee-splitting. It is certainly to the credit of all concerned that the discussion was frank and straightforward. No one was prevented from presenting his point of view and on several occasions effective leadership was offered to the groups or individuals who might have differed widely with previously accepted standards.

In spite of that, no effective organized force developed to support any point of view except the finally adopted decision that the patient must know exactly how much of the fee is paid to each physician concerned with his care.

Now that the controversy is over, it is well to review all of the discussion, the spontaneous or inspired magazine articles and articles in medical magazines. In spite of an occasional intimation to the contrary, all of those who dared discuss this touchy subject were motivated by a desire to have an honest method of doing business that would place the financial consideration of the patient first, and assure all of the

doctors involved some remuneration for their effort. A very few and rather faint efforts in some quarters supported an idea that fees should be paid for referral of patients. This idea never did attract support and was never considered seriously.

The combined bill had considerable support in some quarters and on superficial examination could sound like a logical solution. The supporters of a combined bill, however, were never able to refute successfully the argument that an unitemized combined bill can be an easy way to divide a fee in a manner unknown to and unapproved by the patients. That is why the final decision could be none other than the approval of separate bills as the only ethical procedure, unless a patient specifically requests a combined bill. In this event the bill is to be itemized both as to the amount of the fee and services rendered and each physician is to be paid separately by the patient.

Considerable criticism developed because of the length of time it has taken the House of Delegates of the AMA finally to resolve this problem. Certainly it is to the credit of the parent organization in organized medicine that de-

cisions which affect its members so vitally are not made hurriedly. Actually no one was denied an opportunity to have his say — whether it was by word or letter — to a member of his State Association legislative body or appearance before a Reference Committee at state or national level. In December 1952 the report of the Judicial Council was definite and supported separate bills as the only approved method of billing. The Reference Committee in considering this report however referred to a possible change in the Code of Ethics by its statement "Before any other method can be put into practice it will be necessary to change that portion of the Principles of Medical Ethics" (J.A.M.A. December 27, 1952, p. 1707). This statement apparently reopened the entire problem.

Promptly resolutions appeared from several states asking that an amended Code of Ethics spell out distinctly what is and is not permissible. In response to these resolutions, at the December 1953 meeting the Council on Constitution and By-Laws, charged with revision of the Code of Ethics "recommended that action be deferred until it had conducted a questionnaire survey of the constituent medical associations to determine their policies with respect to the pertinent sections of the Principles of Medical Ethics, and to billing procedures when two or more physicians render medical service to a single patient" (J.A.M.A. July 17, 1954, p. 1078).

Forty state associations answered and these replies were used as a basis for the final decision which was approved in June 1954 at San Francisco.

In response to a Resolution from Illinois, asking for clarification of billing procedures, the Council on Constitutions and By-Laws said "it believes that the Principles of Medical Ethics, Section 6, Chapter I are not clear with respect to billing procedures and that the section now contains many unrelated subjects." Section 6 Chapter I was changed, and it now reads:

#### "PAYMENT FOR PROFESSIONAL SERVICE"

"Sec. 6. The ethical physician, engaged in the practice of medicine, limits the sources of his income received from professional activities to services rendered the patient. Remuneration received for such services should be in the

form and amount specifically announced to the patient at the time the service is rendered or in the form of a subsequent statement.

"Unethical methods of inducement to refer patients are devices employed in a system of patronage and reward. They are practiced only by unethical physicians and often utilize deception and coercion. They may consist of the division of a fee collected by one physician ostensibly for services rendered by him and divided with the referring physician or physicians or of receiving the entire fee in alternate cases.

"When patients are referred by one physician to another, it is unethical for either physician to offer or to receive any inducement other than the quality of professional services. Included among unethical inducements are split fees, rebates, 'kickbacks', discounts, loans, favors, gifts, and emoluments with or without the knowledge of the patient. Fee splitting violates the patient's trust that his physician will not exploit his dependence upon him and invites physicians to place the desire for profit above the opportunity to render appropriate medical service.

"Billing procedures which tend to induce physicians to split fees are unethical. Combined billing by physicians may jeopardize the doctor-patient relationship by limiting the opportunity for understanding of the financial arrangement between the patient and each physician. It may provide opportunity for excessive fees and may interfere with free choice of consultants, which is contrary to the highest standards of medical care."

The Judicial Council issued a new report in response to a resolution introduced by the State of Iowa that they "investigate the factors involved in the matters as presented and determine if there are any new factors or new facets that would cause the Judicial Council to change its opinion as set forth in its report to the House of Delegates at the 1952 Clinical Meeting concerning the billing of patients". Continuing to quote from the report — "The Judicial Council is of the opinion that the only new facet concerning this subject that has come up recently is the case of joint billing to some of the non-profit insurance companies. In many cases the insurance companies insist on a joint or com-

bined bill, but the bill is being paid in most instances by two checks. This is not considered unethical, and all insurance plans which do not pay the individual physician in this manner should be urged to do so."

"The Judicial Council is still of the opinion that when two or more physicians actually and in person render service to one patient they should render separate bills. There are cases, however, in which the patient may make a specific request to one of the physicians attending him that one bill be rendered for the entire services. Should this occur, it is considered to be ethical if the physician from whom the bill is requested renders AN ITEMIZED BILL SETTING FORTH THE SERVICES RENDERED BY EACH PHYSICIAN AND THE FEES CHARGED. THE AMOUNT OF THE FEES CHARGED SHOULD BE PAID DIRECTLY TO THE INDIVIDUAL PHYSICIAN WHO RENDERED THE SERVICE IN QUESTION."

"Under no circumstances shall it be considered ethical for the physician to submit joint bills unless the patient specifically requests it and unless the services were actually rendered by the physician as set out in the bill." This final paragraph of the Judicial Council's report sums up the entire action. The statement in the preceding paragraph that "the fees charged

should be paid directly to the individual physician" leaves no doubt of the intent of the Judicial Council and the House of Delegates in approving the report. A COMBINED, UNITEMIZED BILL COLLECTED BY ONE OF THE DOCTORS AND DIVIDED AS HE SEES FIT WITHOUT THE KNOWLEDGE OF THE PATIENT IS UNETHICAL. This practice along with (Sec. 6 Chapter I) "kickbacks, rebates, discounts, loans, favors, gifts and emoluments with or without the knowledge of the patient" should be promptly discontinued. Failure to do so will certainly endanger the approval of his hospital by the Joint Commission on Accreditation and could be the basis for charges leading to the expulsion from organized medicine.

Thus we see that the Council on Constitution and By-Laws has formulated the policy and the Judicial Council has interpreted it, both with House of Delegates approval. Now we have a new factor, a six man Committee on Medical Practices. The Board of Trustees has recently appropriated funds so that this Committee could employ Rollen Waterson Associates to conduct a pilot study covering the controversial issues of unethical practices including fee splitting and the allied problems of excessive fees, ghost surgery, and unjustified medical and surgical procedures.

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## POLIO TREND

One of the significant characteristics of the disease has been its shifting geographic pattern. The recent rise in the frequency of poliomyelitis has been relatively greatest in states west of the Mississippi River, smallest in the northeastern part of the country, while the middle west and

south occupy an intermediate position in this respect. There are, however, wide variations in the trend of poliomyelitis not only within broad geographic regions but also within individual states. *Morbidity and Mortality Trends in Poliomyelitis. Statistical Bull. Metropolitan Life Insurance Co., July 1954.*

# THE P.R. PAGE



## Political Activity

Election day is November 2. Congress and the Legislature go into session in January.

Now is the time for organized medicine to express itself on the records and personalities of the various candidates. That means by voting.

But — if you are not registered, you cannot vote.

Every county society or branch should urge its members to be sure to register and vote Nov. 2. In some cases, the Woman's Auxiliary has taken on the job of comparing voting lists and membership lists.

An even more effective means of expression is furnished by the political action committees being set up by individual physician groups to raise funds and support specific candidates. And it is entirely legal and proper for any physician to participate.

## North Side Auxiliary Cooks Up a Deal

The Woman's Auxiliary to the North Side Branch of the Chicago Medical Society has bared some of its members' most carefully guarded family secrets in order to help nurse recruitment.

The secrets however, are not the skelton-in-the-closet type. Far from it. In fact, they might be called the "overweight-in-the-dining-room" type, since they are all favorite recipes. Under

the leadership of Mrs. Lloyd A. Gittelson, corresponding secretary, and Mrs. John Brown Jacobs, recording secretary, the branch has collected 100 recipes contributed by 44 of its 70 members, published them in book form, and is selling them at \$2 a copy — two cents a secret.

Mrs. Gittelson hand printed the volume and Mrs. Jacobs did the illustrations. The 50 pages were reproduced by a commercial printer and spiral-bound for convenience. The Auxiliary is selling them to whomever will buy them.

Already the branch has contributed \$100 to each of four hospitals in its territory, to be bestowed on freshmen nurses by the director of the nursing school.

## More About the Legion

Continuation of the attacks on organized medicine by national leaders of the American Legion again emphasizes the need for further participation by eligible physicians — and they are many — at the local level in Legion affairs. If misguided leadership has decided to assault medicine to strengthen its own political position, it is for physicians in their local posts to talk to fellow Legionnaires and explain to them clearly the position of organized medicine. Only an informed membership can withdraw support from rash leaders at the place where it counts.

## Radio Material Available

As county society public relations committees

plan their activities for the coming season, attention is called to the new series of 15-minute radio transcriptions recently made available by the American Medical Association. There are five; two deal with obtaining doctors for a rural community, the others with health councils, hospitals and nursing.

These add to a long series of similar high-quality programs already on hand. Any county society may obtain them, through this office or direct from the American Medical Association.

Why not try to persuade your local radio station to run a 13-week series, sponsored by your society, or even by a local commercial sponsor? In some cases, the local society provides a speaker who supplements the treatment given the subject on the recording with a talk based on related local problems. Your public relations office is available for advice and suggestions and other help, on request.

### **Illinois Recognized**

An early issue of *Medical Economics* — probably October — will carry an excellent piece by Mauri Edwards on the joint medical student loan plan of the Illinois State Medical Society and the Illinois Agricultural Association. The article pays deserved tribute to the work of Dr. Harlan English of Danville, Dr. Edwin S. Hamilton of Kankakee and Dr. Everett P. Coleman of Canton in administering the plan as medicine's half of the joint student loan board, and describes the setup in detail.

Illinois led the way in adopting this method of solving the rural doctor shortage — and without government subsidy. The basic principle of the program is that the way to get country doctors is to make doctors of country boys, and, with 52 students now in process, it looks as though the principle is a sound one.

### **A.M.A. PR Institute**

Two Illinois physicians — both county P.R. chairmen — were on the program of the A.M.A.'s

P.R. Institute at the Drake Hotel, Chicago, Sept. 1 and 2.

Dr. C. Elliott Bell of Decatur, public relations chairman for Macon County, played the recording and showed the slides demonstrating Macon's voluntary insurance studies and program.

Dr. Robert E. Heerens of Rockford, public relations chairman for Winnebago County, spoke as one of four panellists on "How I Evaluate the Day's Mail" — a study of direct mail solicitation.

There was a large representation from the Chicago and Illinois State Medical Societies and their Woman's Auxiliaries among the 250 present.

### **Vacation Manual**

A well-done 48-page booklet on vacations has just been published by the Medical Department of the Equitable Life Assurance Society of the United States (393 Seventh Ave., New York 1, N.Y.). Page by page, it takes the whole family through the vacation process, winter or summer, from planning to poison ivy. It is full of sound sensible advice on such problems as safety, baby care, food and drink protection, illness and medical care, insects, sunburn, and clothing.

It would make a good reception room item. It is available on request from the above address.

### **New Illinois Award**

At the suggestion of the Committee on Medical Service and Public Relations, the Council of the Illinois State Medical Society recently approved the establishment of a series of annual medical public service awards for Illinois. The awards would recognize service, not to the medical profession, but to public welfare in the health field, on the part of any individual or organization. Rules are yet to be formulated and approved, but it is not too early to be thinking about candidates. The first awards will probably be conferred at the annual dinner during the 1955 annual meeting.

# CORRESPONDENCE



## **SOUTHERN MEDICAL ASSOCIATION MEETS IN ST. LOUIS**

The 48th annual meeting of the Southern Medical Association will be held in St. Louis on November 8th to 11th.

This extremely complete meeting is certain to attract many of our members, particularly those in the southern part of the state.

There are sections covering all branches of medicine — scientific and technical exhibits and motion pictures. There is no registration fee.

Room reservations may be made through the Housing Bureau, Southern Medical Association, 911 Locust Street, Room 406, St. Louis 1, Mo.

## **NATIONAL SOCIETY FOR CRIPPLED CHILDREN AND ADULTS**

The National Society for Crippled Children and Adults will be held at the Hotel Statler, Boston, November 3-5, 1954.

Some unusual features are promised at this annual meeting considered as of international importance. Authorities in all fields of work relating to rehabilitation of crippled children and adults will appear on the program.

For complete program and other information, write to The National Society For Crippled Children and Adults, Inc., 11 South LaSalle Street, Chicago 3, Illinois.

## **NEED FOR AUXILIARY GROWTH SHOWN STATISTICALLY**

The Woman's Auxiliary to the Illinois State Medical Society is proud to be the auxiliary to the fourth largest medical society in the world. Yet, your auxiliary holds the embarrassing rank of fiftieth in a membership percentage rating list published by the Auxiliary to the American Medical Association, which includes Washington D.C., Hawaii, and Alaska. 24.6% of Illinois' doctors' wives are doing the work of 9,000 — supposing there are about 758 widowers and bachelors.

Your auxiliary has a place for each physician's wife. This was covered in an editorial published in the September '54 issue of this Journal. Again, for those who reside in a county where organization is not feasible there are the privileges of becoming Members-at-Large. These members, who pay annually dues of \$3.00 to the State Auxiliary Treasurer, automatically become members of the A.M.A. Auxiliary. They are kept informed of Auxiliary activities and are urged to attend neighboring county auxiliaries during the year and take an active part in convention proceedings. The need for new county auxiliaries and increased membership in existing auxiliaries is clearly evidenced by the following statistical report:

WOMAN'S AUXILIARY TO THE ILLINOIS STATE MEDICAL SOCIETY  
WOMAN'S AUXILIARY PERCENTAGE OF THE I.S.M.S. MEMBERSHIP  
SEPTEMBER, 1954

DISTRICT	COUNTY	I.S.M.S. MEMBERSHIP	AUXILIARY MEMBERSHIP	PERCENTAGE I.S.M.S.-W.A.
4	Mercer	8	8	100.0%
9	Saline	26	22	84.6%
2	Bureau	38	32	84.2%
9	Jefferson-Hamilton	31	26	83.8%
8	Edgar	16	13	81.2%
4	Knox	53	42	79.2%
5	Logan	27	21	77.7%
4	Warren	17	13	76.4%
4	Peoria	220	165	75.0%
6	Adams	65	47	72.3%
1	De Kalb	42	30	71.1%
7	Christian	27	19	70.3%
10	Perry	16	11	68.7%
10	St. Clair	150	101	67.3%
7	Macon	112	74	66.0%
8	Vermilion	88	57	64.7%
4	Rock Island	130	83	63.9%
5	Tazewell	41	26	63.4%
11	Kankakee	71	43	60.5%
8	Coles-Cumberland	43	26	60.4%
11	Will-Grundy	136	80	58.8%
8	Champaign	128	73	57.0%
1	Winnebago	201	111	55.2%
2	Livingston	39	21	53.8%
5	Sangamon	177	87	49.1%
1	Stephenson	39	19	48.7%
4	Henry	35	14	40.0%
5	McLean	88	35	39.7%
2	LaSalle	100	34	34.0%
2	Whiteside-Lee	69	21	30.4%
1	Kane	189	57	30.1%
6	Madison	126	33	26.2%
3	Cook	6,083	851	14.0%
Remaining members of Medical Societies (no Auxiliaries)		1,080	Members-at-Large 57	05.2%
TOTAL		9,758	2,401	24.6%
Downstate Percentage Total		3,675	1,550	42.1%
Cook County Branches*:				
	Aux Plaines Branch	627	166	26.4%
	Calumet Branch	191	46	24.0%
	Englewood Branch	342	124	36.2%
	Irving Park Branch	351	40	11.3%
	Jackson Park Branch	529	70	13.2%
	North Shore Branch	783	84	10.7%
	North Side Branch	631	67	10.6%
	Northwest Branch	429	59	13.7%
	South Chicago Branch	341	76	22.2%
	Stock Yards Branch	121	57	47.1%
	West Side Branch	239	62	25.9%

\*Calculations for these Branches not exact because wives may belong to any Branch. They are not restricted to membership in husband's Branch.

Your auxiliary has proven itself capable of promoting good public relations and our most enthusiastic members are the leaders in community affairs. The jolting reports of a recent convention of a leading national organization against the physicians of America alerts us to the still greater need for increased public relations. The success of the doctor is also his wife's success; likewise, the responsibility of the doctor to his community is also his wife's responsibility. For a united effort we need every doctors' wife in Illinois!

Dorothy Young (Mrs. Warren W.)  
Organization Chairman,  
Woman's Auxiliary

**VACCINATION SCAR NOT A  
PASSPORT TO IMMUNITY**

The scar of vaccination against smallpox, long the mark of civilization, has taken on the character of a somewhat battered badge of merit. It is an indictment of the educational process to note that the majority of the public continues to retain the misconception that immunity to smallpox conveyed by such vaccination lasts a lifetime. To many, the scar of vaccination represents an achievement of infancy or early childhood, and its presence is looked upon with a tinge of thankfulness that it was induced before the beginning of memory.

The cold truth is that smallpox vaccination does not induce a lifelong immunity, but protects for periods of time which may vary with the individual. There is sufficient evidence that protection is actually of relatively short duration and may be lost in appreciable amount in from 3 to 5 years, on the average. Although similar experiences may be recorded daily throughout the country, it is of interest to cite a recent example of the false sense of security which the presence of a vaccination scar seems to provide.

In an institution in south central Illinois the

character of reactions to revaccination for smallpox was noted in a group of 1,322 individuals. These were categorized as to presence or absence of a scar from previous vaccination, (see table below). It is worthy to note that among 909 with scar of previous vaccination, 399 or 43.9% developed a primary "take"—evidence of virtually total loss of immunity. Only 48.8%—approximately one-half—revealed either immune or accelerated reactions, the latter denoting a partial but definite loss of full immunity.

We have but to look upon the re-introduction of smallpox into communities of Europe and the large reservoirs of infection in countries brought closer to us by modern modes of travel to view with alarm the neglect of our status of immunity to this disease. When coupled with the findings of immunization surveys recently conducted in Illinois, we can do naught but take serious stock of the situation and re-emphasize our efforts in education of our people.

A vaccination scar is *not* a passport to immunity. Smallpox revaccinations must be repeated, preferably at intervals 3 years and certainly not longer than 5. Only in this way will we have the assurance that the population is immune to this dread disease which may be re-introduced at any time.

Data (1953) courtesy Dr. E. A. Kuehn, Vandalia, Ill. From the Illinois Dept. of Public Health.

**AMERICAN COLLEGE OF SURGEONS  
ANNUAL MEETING**

The largest meeting of surgeons in the world, the 40th annual Clinical Congress of the American College of Surgeons, will be held in Atlantic City, New Jersey, November 15 to 19. More than 10,000 Fellows of the College and their guests will gather to discover, to inform and to learn. This postgraduate education meeting will present recent surgical developments through a wide variety of programs, including panel discussions, symposia, surgical forums, motion pictures, cine clinics, color television

Vaccinal Reactions, According to Presence or Absence of Previous Vaccination Scar

Reaction	Scar Present		Scar Absent	
	No.	%	No.	%
Primary 'take' .....	399	43.9	268	64.9
Immune and accelerated .....	444	48.8	130	31.5
None .....	66	7.3	15	3.6
Total .....	909	100.0	413	100.0

and exhibits. Dr. Charles deT. Shivers, Atlantic City, is Chairman of the Atlantic City Advisory Committee on Arrangements.

Dr. Frank Glenn, New York, current President will preside at the opening evening session, at which Dr. Alan Gregg, New York, and Dr. Robert H. Kennedy, New York, will be guest speakers. On the final evening Dr. Alfred Block, Baltimore, will be installed as President for the coming year.

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### **PROFESSIONAL CONSULTANTS FOR DEPARTMENT OF PUBLIC WELFARE**

Upon the recommendation of the Screening Committee for Professional Appointments, Dr. Otto L. Bettag, Director of the Illinois Department of Public Welfare, recently announced that four additional consultants have been appointed. These consultants will provide expert assistance to the medical staff in the State hospitals on problems and research in various medical and surgical specialties.

The appointments include the following:

Dr. Nathaniel Apter, Professor and Head of the Department of Psychiatry of the University of Chicago, as Consultant in Psychiatry to the Illinois Department Welfare. One of Dr. Apter's early projects will be research into the care, treatment, and prevention of schizophrenia.

Other consultants now assisting the Department in the field of psychiatry include: Dr. Ralph Gerard, Dr. Roy R. Grinker, Dr. W. H. Haines, Dr. Alan Lieberman, Dr. I. Spinka, and

Dr. W. C. Wilson. All are diplomates in psychiatry.

Dr. Frederick Falls, Professor and Head of the Department of Obstetrics and Gynecology at the University of Illinois College of Medicine, as Consultant in Obstetrics and Gynecology to the Illinois Department of Public Welfare. Dr. Falls plans to take immediate steps to assure adequate care and treatment to all patients requiring gynecological and obstetrical attention within the State mental institutions. He is a diplomate in obstetrics and gynecology.

Dr. Leonard Krasner, Chief of Tuberculosis Service at the Downey Veterans Administration Hospital, as Consultant in Chest Diseases and Thoracic Surgery to the Illinois Department of Public Welfare. Dr. Krasner at present is establishing a chest surgical unit at the Chicago State Hospital. Mental patients with tuberculosis in Illinois State Hospitals exceed 1,800. The Department hospitalizes more tuberculosis patients than any other tax-supported agency in Illinois. Dr. Krasner is a member of the American Board of Surgery and the American Board of Thoracic Surgery.

Dr. Max Sadove, Professor of Surgery and Head of the Division of Anesthesiology of the University of Illinois College of Medicine, as Consultant in Anesthesiology to the Illinois Department of Public Welfare. Dr. Sadove will organize the Division of Anesthesiology for the Illinois Department of Public Welfare. He is a diplomate of the American Board of Anesthesiologists.

# COUNCIL MEETING MINUTES

The regular meeting of the Council was held at the Hotel Sherman, Chicago, on Sunday, August 8, 1954, with the following present: O'Neill, Vaughn, Norbury, Limarzi, Redington, Camp, Lundholm, Stone, Earl Blair, Piszczek, Oldfield, Reichert, Hesselstine, C. P. Blair, Reisch, Goodyear, Newcomb, English, Montgomery, Fullerton, Hamilton, Lewis, Hopkins, Cross, Bettag, Hodge, Hutton, Paul Baur, Fowler, Van Dellen, Scatliff, Oblinger, Neal, Leary and Frances Zimmer. Motion: Stone-Fullerton, that minutes of June meeting be approved as mailed to members; motion carried.

Vaughn reported as president telling of recent meetings he has attended; the A.M.A. in San Francisco, the Beaumont Memorial Session at Mackinac Island, and a tuberculosis control meeting on July 28, at which Head, Hutton and Piszczek were speakers. He also officially greeted the French nurse, "the angel of Dien Bien Phu" during her visit to Chicago. He attended the I.P.A.C. Medical Advisory Committee meeting the previous evening, as well as the Executive Committee session. He discussed the coroner situation, and urged the early publication of the Medical History of Illinois.

Chas. Blair told of a meeting he recently attended with representatives of the Department of Registration and Education, at which plans were discussed which would result in the Department having the power to prosecute certain violations of the Medical Practice Act, applying principally to individuals "practicing without a license". This would necessitate changes in existing laws. Other representatives at this interesting session from Certified Public Accountants, Dentists, and Physicians. Blair told how the proposed legal changes would be of much benefit to the State Department of Registration and Education. Motion: Blair-Fullerton, that the pro-

posed changes be approved and that the Society again be represented when further discussions were to be made on this subject; motion carried.

Norbury told of some recent meetings he had attended, especially a joint meeting of the Jersey-Greene Societies, with Dr. Newcomb, as Councillor for the district. He stated that he would discuss some of the current mental health problems later in this session. Camp discussed the financial statement which had been passed out to the members, commenting on receipts and expenditures since the last meeting. By proper action, the report was accepted and placed on file.

O'Neill, as Chairman of the Council had no special report, but would comment upon some matters taken up the preceding evening by the Executive Committee later in the session.

Hopkins reported as Chairman of the Committee on Medical Service and Public Relations which met the previous day with Attorney Walter Oblinger and John W. Neal. Oblinger had accepted the position as Associate Counsel for the Society, to carry on various functions in Springfield. He will have the cooperation of Mr. Neal in this work, and James W. Leary, as Public Relations Director will likewise render all possible assistance. Hopkins discussed a suggestion made by Mr. Leary relative to making "medical public service awards" to individuals or groups contributing to the public health of the community. Certificates or plaques could be developed for the presentations. Leary was asked to elaborate on this portion of the report, stating that this idea could be worked out as a public relations gesture, based upon contributions to public health in the community. Possible candidates for the awards would be legislative members, Health Improvement Associations, Newspapers, women's clubs, service clubs, etc. This would be a good

opportunity to give Society recognition for work well done.

Hopkins stated that the Committee recommended to the Council that they be permitted to proceed, work out general plans, establish categories for the awards, then submit same later for Council action. Motion, Piszczek-Hesseltine, that this recommendation be approved; motion carried.

Oblinger was introduced to the Council and gave his assurance that he will do everything possible to further the best interests of the organization he is proud to represent. He has met with Neal and Leary, and plans are being developed for his activities during the next year. He proposes to keep in touch with the Secretary's office and will want to use the personnel and equipment in the office, in carrying out his functions.

Leary referred to the favorable publicity resulting from an article warning the public against any self-imposed low sodium diet.

Limarzi reported as Chairman of the Postgraduate Education Committee, and told of an interesting meeting of his committee on August 5. The Committee approved a continuance of the three types of programs being offered; the full scale afternoon and evening conference; the short three man dinner conference, and the circuit rider type of clinical teaching. It was decided to ask the host society and other participating societies to suggest subjects to be presented at each conference. Programs should emphasize diagnosis and therapy, with little emphasis on laboratory and research. The types of programs at the larger conferences should vary according to the local preferences. The panel type presentations will be continued.

The matter of inviting ladies to the dinner and evening session will be left to the local groups. When programs are of interest to other professions (dentists, pharmacists, or lawyers) these groups should also be extended invitations to the Conference. Reference was made to several conferences set up for the fall, and several more are being considered for October and November. Places and dates already arranged were reported. Limarzi stated that the survey which had been under contemplation for the past two years would not be conducted.

Kirby as Co-Chairman of the Committee stated that the main weakness in the P. G. program as he saw it, was in developing the attendance throughout the state. The committee this year will do everything possible to stimulate local interest and get the physicians in any given area to the meetings. Oblinger stated that he would like to attend these conferences to get acquainted with physicians in the various areas of the state.

Montgomery reported as chairman of the Medical Advisory Committee to the I.P.A.C. which met the preceding evening with officials of the State Agency. The customary problems were reviewed, there were several visitors, members of county society advisory committees, who were interested in the procedures

and gave their impressions as to the procedure and functions of the committee. Some difficult problems arising in the work of the State I.P.A.C. routine were discussed and the proper procedures recommended by the committee.

Blair gave a short informal report of activities of the Educational Committee, whose secretary was on vacation.

Hutton, as chairman of the Committee on Medical History reported that Dr. D. J. Davis has the entire manuscript for the second volume in his possession. All contributions have been received; the work of condensing the material, elimination of duplications, etc., is complete. The material is now ready to go to the publishers, when the go ahead signal is given. He referred to actions taken by the House of Delegates last May when they unanimously petitioned the Council to authorize the publication of the volume as soon as possible. Hutton discussed the plans under consideration for sale of the book, through the Illinois Medical Journal, Secretary's office, and through activities of the Woman's Auxiliary. Following some discussion of the report, a motion was made by English, second by Norbury, that a committee consisting of Reichert, Oldfield, Hutton, Charles Blair, Stone and O'Neill be named as the publication committee, to negotiate with publishers and get the work under way. Motion carried.

Cross as Director, Illinois Department of Public Health reported on several items of general interest. He told of the 1953 Legislative Act relative to the licensing of hospitals in Illinois as a function of his department. This applies to all hospitals other than those operated by the federal government and those operated or licensed by the State Department of Public Welfare. The Department set up a set of minimum standards to be approved by the Hospital Licensing Board. The forms to be used will be available about January 1, 1955. Hospitals in Illinois which fail to meet the minimum standards approved by the Licensing Board, may be allowed one year from date, to conform.

All hospitals will therefore be expected to meet the requirements for obtaining the state license by January 1, 1956. The members of the Hospital Licensing Board, appointed by Governor Stratton, are:—

Mr. George K. Hendrix, Springfield Memorial Hospital

Dr. Theodore R. Van Dellen, Chicago

Dr. Harlan English, Danville

Dr. George H. VanDusen, Administrator, Christian Welfare Hospital, East St Louis

Rt. Rev. Msgr. John W. Barrett, Director, Catholic Hospitals

Mr. I. R. Abbott, Decatur-Macon County Hospital

Mr. Elmer E. Abrahamson, Norwegian-American Hospital, Chicago.

Dr. Cross in his maternal welfare report, stated that since the organization of the Department in 1918, the actual number of deaths among women at-

tributed to puerperal causes in Illinois has declined from 1,160 to 91 in 1953. The maternal death rate in Illinois declined from 8.9 per 1,000 live births in 1918, to 0.4 in 1953. Improvement has resulted from cooperation between the medical profession and the department. He told of the study of maternal deaths by the State Society Committee on Maternal Welfare, under Frederick H. Falls, chairman. In 1953 85 deaths associated with gestation were studied. Of these, 40 were due to non-obstetrical conditions, and 45 were charged to obstetrical causes. Of the deaths due to obstetrical causes, 42.2% were from hemorrhage, 20% to toxemia of pregnancy, 17.7% to embolism and 11.1% to anesthesia. Of the non-obstetrical cases, heart disease was the principal factor, accounting for 37.5%. In 1948 the maternal mortality per 1,000 live births was 0.48 and in 1953 it was 0.36 per 1,000 live births. Dr. Cross also discussed the current handling of gamma globulin which has been published in this Journal, and also the poliomyelitis situation. The cumulative totals to date (Aug. 8) was 265 cases in Illinois as compared with 427 cases in 1953.

Dr. Bettag as Director of the Illinois Department of Public Welfare gave an interesting report on work within his department. The Illinois Psychiatric Council has developed a series of recommendations for the Department and their suggestions have been followed 100%. This Council is made up of men from various schools and institutions in Chicago and represent some of the top men in that specialty in the entire country. The group meets monthly and considers matters pertaining to policy. He told of the screening committee which passes upon all applications for positions in the department. No appointment has been made which was not first approved by this committee. Judgment is rendered on ability only, politics and religion being disregarded completely.

In 1953 only 2.8% of the employees were under civil service, and at this time 77% are so classified. Bettag referred to the monthly bulletin which is sent to a mailing list of some 16,000 people and he solicits suggestions for its improvement, as well as material which would be acceptable in such a publication. He gave assurance that his Department was working with the State Society Committee on Mental Health, and referred problems to this group for its recommendations.

Dr. Norbury, Chairman of the Committee on Mental Health, discussed the interesting report given by Dr. Bettag and commented upon the problems referred to his committee. He had received the three volume report on Illinois institutions made under supervision of the American Psychiatric Association as submitted to him by Dr. Bettag. He commented upon the request for the mailing list of the membership of the State Society so the Psychiatric Bulletin can be sent to all members for the next year. Norbury stated that the care of 47,000 patients in

state hospitals is a big problem, and he urged the entire membership to render all possible cooperation and assistance to the State Department of Public Welfare and its Director. By proper action mailing list was made available for the sending of this Bulletin for the next year.

Scatliff reported as Chairman of the Advisory Committee to the Woman's Auxiliary, and commented upon the recent report showing that the Auxiliary in Illinois ranked 47th in the nation in regard to the membership in relation to the total membership of the state society. This is a problem which should and could be solved, by united effort on the part of the membership of the Society. This should be widely publicized throughout the state in the effort to get more members for the Auxiliary in every Illinois county. Scatliff stated that the Auxiliary is willing and anxious to aid in every way possible, the sale of the medical history when it has been published. Motion, Blair-Stone, that the Auxiliary be asked by the Council to participate in the sale of the history. Motion carried.

A letter was received from the A.M.A. asking if the State Society has a committee on alcoholism, or a committee which would be willing to cooperate with the A. M. A. Committee on Alcoholism. Motion, Piszczek-Fullerton, that the function be given to the Committee on Mental Health. Motion carried.

By proper action, two cases of "hardship" as reported by county societies, were approved and the members are to have dues waived for the current year, and the A.M.A. be notified of this action with a request for similar action by that Association.

An invitation had been received requesting that delegates be selected from this Society to attend the meeting of the Midwest State Medical Society Executives, to be held at East Lansing, Michigan on November 20. By proper action, the president, secretary and the Secretary's Executive Assist-session.

Dr. Bettag had discussed the proposed salary scale to be considered by his Department. Norbury stated that his Committee on Mental Health had approved the proposed scale, and he moved that the Council authorize the Committee to write a letter stating the approval of this scale by the Committee and by the Council—second by Piszczek and carried.

A list of candidates for Emeritus, Past Service and Retired members, as approved by their local societies, appeared on the agenda. These had been checked in the secretary's office and were found to be eligible for their respective classifications. Motion, Reisch-Lewis that they be so elected. Motion carried.

The bills had been audited by the Finance Committee and by proper action (Lewis-Fullerton) were approved.

The Council adjourned at 12:30 P.M., to meet in regular session on Sunday, October 24, 1954.

Harold M. Camp, M.D.  
Secretary

## NEWS OF THE STATE



### COOK

**Society News.**—Dr. Torsten Gordh, assistant professor and chief anesthetist at Karolinska Sjukhuset, University Clinic of Stockholm, Sweden, addressed the Illinois Society of Anesthesiologists, September 21, at the Veterans Administration Research Hospital, 333 East Huron Street. His subject was "Problems in Anesthesia in Sweden."

**Billings Lecture.**—Randall Sprague, Rochester, Minn., will give the ninth Frank Billings Lecture of the Mary Holmes Nichols and Thomas Lewis Gilmer Foundation, October 25, at the Drake Hotel. The meeting will be held under the joint sponsorship of the Institute of Medicine of Chicago and the Chicago Society of Internal Medicine.

**New Head of Obstetrical Department.**—Dr. Aaron E. Kanter has been appointed Professor and Chairman of the Department of Gynecology and Obstetrics at The Chicago Medical School, President John J. Sheinin announced recently.

Dr. Kanter is a graduate of the University of Chicago and of Rush Medical College. His post graduate work was pursued at Trinity College, Dublin, and the Universities of Glasgow, Paris and Bordeaux and Vienna.

Dr. Kanter is a veteran of World War I. He served as a Lieutenant in the Navy Medical Corps. Attending obstetrician and gynecologist at the Presbyterian and Mount Sinai Hospitals and attending Gynecologist at the Cook County Hospital, Dr. Kanter is a past president of the Chicago Gynecological Society.

**Fred Falls Retires to Devote Full Time to Private Practice.**—Frederick H. Falls has retired as head of the department of obstetrics and gynecology at the University of Illinois College of Medicine, effective

August 31. The resignation marks the end of twenty-eight years of service at the university. Prominently known for his work as a teacher, Dr. Falls' reputation as a physician and a creator of scientific exhibits is internationally renowned.

**Arthur Kirschbaum Goes to Baylor.**—Dr. Arthur Kirschbaum has resigned as professor and head of the department of anatomy, University of Illinois College of Medicine, to become head of the anatomy department at Baylor University College of Medicine, Houston, and a similar position in the College of Dentistry of the University of Texas. The resignation from Illinois was effective August 31.

**New Medical Director of Research and Educational Hospitals.**—Dr. Donald J. Caseley has been appointed medical director of the Research and Educational Hospitals and associate dean of the University of Illinois College of Medicine. Prior to taking on his new appointments, Dr. Caseley was medical director of St. Luke's Hospital. According to the Newsletter of the Chicago Professional Colleges, the appointment of Dr. Caseley has established a separate office of medical director of the Research and Educational Hospitals, which was formerly combined with the deanship of the College of Medicine. In the new capacity, Dr. Caseley will cooperate with Dr. Granville A. Bennett, dean of the college of medicine, in the preparation of the budget and specifically on budgetary provisions relating to the hospitals and the medical school. In addition, he will assist the dean on all educational matters, especially in programming and implementing the educational and research activities in the Research and Educational Hospitals and the work of clinical clerks. He will also serve as liaison officer repre-

senting the dean in educational matters and staffing at the Illinois Eye and Ear Infirmary.

**Tom Jones Retires.**—Prof. Thomas S. Jones, for forty-one years a faculty member of the University of Illinois Chicago Professional Colleges, will retire from his position as professor and head of the department of medical and dental illustration. Regarded as one of the leading medical illustrators in the country, Mr. Jones has organized and developed the department and has been active in a teaching capacity.

**New Director of Nurses.**—Miss Margaret Filson, research associate of the University of Pittsburgh School of Nursing and former director of nursing service at the University of Minnesota Hospitals, has been appointed director of nurses at the University of Chicago Clinics, Ray E. Brown, superintendent of the Clinics, announced August 25.

Miss Filson, who has also been appointed an assistant professor of nursing education in the University's division of social sciences, assumes her new duties immediately. She succeeds Miss Dorothy Morgan, who is now affiliated with the Elizabeth Steele Magee hospital, Pittsburgh.

**Changes in Faculty at Northwestern.**—Four faculty members of Northwestern University's medical and dental schools have been promoted to the rank of full professor, it was announced by Payson S. Wild, vice president and dean of faculties.

In the medical school, those promoted and their departments were Dr. Ronald R. Greene, obstetrics and gynecology; Dr. Robert E. Stone, nutrition and metabolism, and Dr. Willis J. Potts, surgery. Promoted in the dental school was Stanley C. Harris, physiology and pharmacology.

Dr. Greene, of 1100 Oak, Evanston, will occupy the newly established Anna Ross Lapham professorship. He joined Northwestern's faculty in 1937 after receiving his M.D. degree and master's in physiology from the University. A member of the American Gynecological Society and other professional organizations, he is a frequent contributor to scientific journals. He is senior attending in obstetrics and gynecology at Wesley Memorial hospital, Chicago.

Dr. Stone is on the staff of Northwestern's nutrition clinic at the Hillman hospital, Birmingham, Ala. He joined the faculty there in 1949, previously having taught at the University of North Carolina medical school. A captain in the Army medical corps during World War II, he is an associate in the American College of Physicians and a member of several other professional organizations.

Dr. Potts, of 614 Fair Oaks ave., Oak Park, received his M.D. degree from Rush Medical College. Before joining Northwestern's faculty in 1946, he taught at Rush and at the University of Illinois. A fellow of the American College of Surgeons, he was a medical corps colonel during World War II. He is surgeon-in-chief at Children's Memorial hospital, Chicago.

Dr. Harris, of 806 Milburn, Evanston, joined Northwestern's faculty in 1945 after receiving his doctorate in physiology from the University's medical school. A member of the American Physiological Society and other professional groups, he is author of numerous articles on the physiology and pharmacology of pain and analgesia (insensibility to pain).

**Personal.**—News officers of the American section of the International College of Surgeons include Edward L. Compere, a vice president; Oscar B. Nugent, treasurer, and Karl A. Meyer, secretary, all of Chicago.—Dr. August F. Daro, chairman of the women's section of Columbus Hospital, has been appointed attending physician in gynecology at Cook County Hospital where he has been a staff member for twenty years.

**Award Goes to Dr. Brams.**—One of the four Howard W. Blakeslee \$500 prizes, awarded annually by the American Heart Association for outstanding reporting on heart and blood vessel diseases, went to William A. Brams, M.D., Chicago, September 14. Dr. Brams, a senior attending surgeon at Michael Reese Hospital and associate professor of medicine at Northwestern University Medical School, was honored for his book, "Managing Your Coronaries."

**Harvey Allen Receives Fulbright Grant.**—Dr. Harvey S. Allen, associate professor of surgery at Northwestern University Medical School, has received a Fulbright grant to lecture for three months next year in Copenhagen, Denmark. Dr. Allen will be in Denmark from January through March 1955.

**University Receives Grant.**—Eli Lilly and Company recently made a sum of money available to the University of Chicago School of Medicine to support a study of the peptic ulcer in relation to certain hormonal and enzymological aspects under the direction of Joseph B. Kirsner, M.D., of the department of medicine.

**New Appointments.**—Two University of Chicago-trained surgeons have recently been added to the staff of the department of surgery, Dr. Lowell T. Coggeshall, dean of the division of biological sciences of the University, announced August 18. Dr. Joseph P. Evans, a native of LaCrosse, Wisconsin, will become professor of neurosurgery. Dr. John Van Prohaska, formerly professor of surgery at the University of Illinois, has been appointed professor of surgery at the University of Chicago. Dr. Evans received his M.D. at Harvard, his Ph.D. in experimental surgery at Canada's McGill University. He interned in surgery at the University of Chicago clinics in 1930-31. He subsequently served on the staffs of McGill University and conducted research in physiology at Cambridge University and at London University. Until his appointment, he has been associate professor of surgery in charge of neurosurgery at the University of Cincinnati Medical School. His appointment was effective October 1, 1954. Dr. Van Prohaska, born in Bohemia, received

his M.D. at the University of Chicago in 1934. He then became a Douglas Smith fellow in the department of surgery and instructor in surgery in 1939.

**Changes in Faculty.**—Seven full time appointments to the Faculty of The Chicago Medical School were announced by Dr. John J. Sheinin, President. The appointments are: Dr. Arthur A. Billings, 1642 East 56th Street, Instructor in Medicine; Julius Goldberg, Ph.D., Assistant Professor of Microbiology; Dr. Henry Rappaport, Mount Sinai Hospital, Associate Professor of Pathology; Dr. Earl H. Silber, 6041 North Campbell, Associate in Medicine; Dr. Morton Smith, Michael Reese Hospital, Instructor in Medicine; Dr. J. D. Wheeler, Mount Sinai Hospital, Instructor in Pathology; and Dr. Lester Wishingrad, 809 South Marshfield, Clinical Assistant in Pediatrics.

Dr. Sheinin also announced the appointment of five practicing physicians to the faculty: Dr. Gilbert Iser, 3403 West Lawrence, Clinical Assistant in Ophthalmology; Dr. Robert F. Jeans, 1860 North Springfield, Clinical Instructor in Psychiatry; Dr. Gershen L. Schaefer, 2106 Hood Avenue, Clinical Assistant in Medicine; Dr. William Schumer, 8621 Central Park, Skokie, Illinois, Clinical Instructor in Surgery; Dr. Sidney N. Goldman, 6200 North Claremont, Clinical Assistant in Urology.

Dr. Albert Goldman, 4957 North Wolcott, returns from military service to his position as Assistant in Pediatrics.

**Appointments at Presbyterian.**—Dr. Edward J. Beattie, Jr., 1350 North Lake Shore Drive, Chicago, Illinois, has been appointed Chairman of Presbyterian Hospital's Department of Surgery, effective immediately, it was announced September 16 by Franklyn B. Snyder, president of the hospital's Board of Trustees.

A graduate of Princeton University and the Harvard Medical School, Dr. Beattie took his post graduate training at Peter Bent Brigham Hospital, Boston, Massachusetts; Hammersmith Hospital, London, England, and George Washington University School of Medicine, Washington, D. C.

Prior to joining the Presbyterian Hospital Staff in 1952 at Chief of Thoracic Surgery, Dr. Beattie served as Consultant in Cardiovascular Surgery at Mount Alto Veterans Administration Hospital in Washington, D. C. His former hospital staff appointments include: Chief, Thoracic Surgery, Galling Municipal Hospital and Consultant, Thoracic Surgery at George Washington University, Walter Reed Hospital and Newton D. Baker Veterans Administration Hospital. His teaching appointments include Harvard Medical School, George Washington University and the University of Illinois, the latter from 1952 to the present.

Dr. Beattie is a member of the American Association of Thoracic Surgery.

The new chairman succeeds Dr. Edwin M. Miller. Dr. Benjamin Morris Gasul, 3172 Sheridan Road, Chicago, Illinois has been appointed Chairman of the Department of Pediatrics of Presbyterian Hospital, it was announced today (September 16), by Franklyn B. Snyder, President of the hospital's Board of Trustees. The appointment is effective immediately.

Dr. Gasul received his doctor of medicine degree from Rush Medical college in Chicago in 1925, and his master of science degree from the University of Illinois. His internship at Cook County Hospital and residency at the Research hospital of the University of Illinois, was followed by graduate work at Hospitant, Professor Pirquet's Children's hospital in Vienna and the University of Vienna and Berlin.

In addition to his post at Presbyterian, Dr. Gasul is Director of the Pediatric Cardiophysiology Department at Cook County Children's Hospital and Attending pediatrician there. He is Associate Professor of pediatrics in charge of Pediatric Cardiology at the University of Illinois College of Medicine as well as Professor of Pediatrics at the Cook County Graduate School of Medicine.

The new chairman is a member of the Chicago Medical Society; American Medical Association; Institute of Medicine of Chicago; Chicago Pediatric Society; American College of Physicians; American Academy of Pediatrics; and American Board of Pediatrics.

Dr. Gasul succeeds Dr. Heyworth N. Sanford.

**Grants-in-Aid.**—A grant of \$4,500 from the Asthmatic Children's Aid was presented to the Chicago Medical School by Mrs. Burton Golden, 2804 North Sawyer Avenue, President, and Mrs. Ira Silverstein, 1127 Columbia, Service Chairman. The grant is toward the research project, "The Role of Bacteria, Virus, and Related Infectious Agents in the Production of Bronchial Asthma". The principal investigators are Dr. A. L. Aaronson, 431 Roscoe, Assistant Professor of Medicine at The Chicago Medical School and Director of the Allergy Clinic at Mount Sinai Hospital, and Dr. Morris A. Kaplan, 534 Stratford Place, Assistant Professor of Medicine at The Chicago Medical School.

The Bertha Gerber Memorial Cancer League established the Bertha Gerber Memorial Cancer League Fellowship at The Chicago Medical School with a grant of \$3,000 for the present year. The money is to be used to support a young scientist engaged in cancer research in the Department of Oncology under Dr. Philippe Shubik, Director. Mrs. Rose Lucas, 3610 Leland Avenue, Retiring President, made the presentation to Dean Francis J. Mullin.

## LAKE

**Fifty Year Member.**—Theodore Proxmire, Lake

Forest, was inducted into the Fifty Year Club of the Illinois State Medical Society at a recent meeting of the Lake County Medical Society. Edward H. Weld, Rockford, Past President of the Illinois State Medical Society, presented the insignia of gold pin and certificate, emblematic of fifty years in the practice of medicine.

### **MADISON**

**Society News.**—"Some Surgical Principles in the Management of Cancer" was discussed before the Madison County Medical Society at St. John's Methodist Church, Edwardsville, September 2. The speaker was Dr. Charles Eckert, associate professor of surgery, Washington University School of Medicine, St. Louis.

### **PEORIA**

**Society News.**—Dr. Ormand C. Julian, Chicago, addressed the Peoria Medical Society at the Hotel Pere Marquette, September 21, on "Surgical Treatment of Lesions of the Aorta."

### **VERMILION**

**Society News.**—Arthur DeBoer, attending surgeon at Wesley and Children's Memorial Hospital, Chicago, discussed "Surgical Emergencies in the New-born" before the Vermilion County Medical Society, September 7.

### **ROCK ISLAND**

**Society News.**—Dr. D. L. Tabern, Abbott Laboratories, North Chicago, addressed the Rock Island County Medical Society, September 14; his subject was "What the Physician Can Do with Radioisotopes."

**District Meeting.**—Edward L. Compere, professor and chairman of the department of orthopedic surgery and supervisor of orthopedic postgraduate training, Northwestern University Medical School, addressed the Iowa-Illinois Central District Medical Association at Watch Tower Inn, Rock Island, September 22, on "Medical Legal Aspects of Industrial Medicine." Discussion was opened by Dr. L. J. McCormick, Moline. Dr. Alphonse McMahon, professor of internal medicine, St. Louis University School of Medicine, St. Louis, will address the November 17 meeting of the association, the subject to be announced later.

### **SANGAMON**

**Society News.**—"Medical and Surgical Considerations of Biliary Tract Disease" were discussed by Drs. Jesse C. Lockhart and Charles D. Branch before the Sangamon County Medical Society, September 2. Both speakers were from Peoria.

**New County Society Officers.**—Dr. David Lewis was elected president of the Sangamon County Medical Society recently. Other officers elected are: Drs. Jacob E. Reisch, vice president; William DeHollander, secretary treasurer; Emmett Pearson and J. Keller Mack, board of directors (1955-1958); Kenneth Schnapp and Darrell Trumpe, delegates to

the Illinois State Medical Society, and J. Marvin Salzman and Thomas F. Harmon, alternate delegates.

### **WINNEBAGO**

**New Executive Secretary for Winnebago.**—Mr. Floyd Tarbert has been appointed executive secretary of the Winnebago County Medical Society, Rockford. He succeeds Mr. Douglas Thorsen, resigned.

### **GENERAL**

**Announcement of the Van Meter Prize Award.**—The American Goiter Association again offers the Van Meter Prize Award of Three Hundred Dollars and two honorable mentions for the best essays submitted concerning original work on problems related to the thyroid gland. The award will be made at the annual meeting of the Association which will be held in Oklahoma City, Oklahoma, April 28, 29 and 30, 1955, providing essays of sufficient merit are presented in competition.

The competing essays may cover either clinical or research investigations; should not exceed three thousand words in length; must be presented in English, and a typewritten double space copy in duplicate sent to the Secretary, John C. McClinck, M.D., 149½ Washington Avenue, Albany, New York, not later than January 15, 1955. The committee, who will review the manuscripts, is composed of men well qualified to judge the merits of the competing essays.

A place will be reserved on the program of the annual meeting for the presentation of the Prize Award Essay by the author, if it is possible for him to attend. The essay will be published in the annual proceedings of the Association.

**Launch New Nursing Aide Training Project.**—The Illinois Department of Public Health launched a new nursing aide training project in August to help hospitals develop on-the-job training for auxiliary nursing personnel—nursing aides, orderlies, attendants, and others.

A series of workshops will be conducted throughout the state for nurse representatives who will be responsible for the teaching programs in their hospitals. The first is to be held August 5 and 6 at St. John's hospital, Springfield.

This training project is being developed on a nationwide basis by the National League for Nursing, the American Hospital Association and the U. S. Public Health Service. In Illinois, it is being carried out by the Illinois Department of Public Health with assistance from the state Division of Vocational Education, the Illinois League for Nursing, the Illinois Hospital Association and other organizations.

Miss Maude B. Carson, R.N., chief of the state health department's Bureau of Nursing, heads the planning committee. Mrs. Armina Farrar, R.N.,

Springfield, is coordinator and teacher-trainer for the project.

Since 1941, employment of nursing aides in hospitals has nearly doubled. These employees play an increasingly important part in the nursing care of patients. Well-trained aides will be able to give more skilled attention to patient needs, state health authorities believe.

**Officers of Specialty Societies.**—Albert M. Wolf, Chicago, was recently chosen president-elect of the Illinois Association of Blood Banks for the forthcoming year, and Dr. J. Garrott Allen, also of Chicago, was installed as president; John E. Maloney, Princeton, was made vice president, and Harold M. Grimm, Chicago, secretary-treasurer.—Recently elected officers of the Chicago Neurological Society are Drs. Benjamin Boshes, president; John J. Madden, vice-president; Oscar Sugar, secretary-treasurer, and Douglas N. Buchanan, councilor.—At a recent meeting of the Chicago Society of Allergy, Dr. Max Samter was inducted into the presidency; Simon S. Rubin, was named president-elect, and Norman J. Ehrlich, secretary-treasurer.

**Units Strengthen Public Health Activities.**—County and multiple-county health departments serving 27 counties in Illinois have added great strength to the public health machinery of the state, according to Dr. Roland R. Cross, director of the Illinois Department of Public Health, in an address of welcome delivered to the 10th annual conference of the Illinois State-Wide Public Health Committee here, September 17.

State and local health authorities from throughout the state were meeting at the Congress hotel to promote establishment of full-time, locally administered and financed health departments in every Illinois county.

"The state has not unloaded responsibility for public health services entirely on local shoulders," Dr. Cross said. "The General Assembly appropriates three quarters of a million dollars annually for grants-in-aid to local health departments. The State Department of Public Health reorganized its field staff so as to give better and quicker consultative and other services as needed. In this way the county with a full-time health department is in a position to realize all the advantages that modern public health can offer and at the same time retain the management of its own affairs."

Dr. Cross believes the time is ripe to bring full-time health service to the 75 counties not served by county health departments.

"Health problems are more likely to multiply than to decrease because of the increasing and aging population on the one hand and growing industrialization on the other," he said. "The present trend, moreover, is to shift responsibility for public service back to local government. During the past two

years the federal government has reduced substantially its financial grants to states for public health purposes and has served notice that more reduction will be made in the future. The policy of the State Department of Public Health is to decentralize services.

"Thus it is particularly important at this time," Dr. Cross concluded, "to go forward vigorously with the program for establishing and strengthening local health departments and particularly county and multiple-county health departments."

**"Your Doctor Speaks".**—Since the last publication of participants in the radio series "**Your Doctor Speaks**" over FM Station WFJL, sponsored by the Educational Committee of the Illinois State Medical Society, the following physicians have appeared in transcribed broadcasts:

**Warren A. Clohisy, Jr.**, clinical assistant in surgery, Stritch School of Medicine of Loyola University, May 27, on Severe Burns.

**Norman M. Frank**, attending physician, MacNeal Memorial Hospital, Berwyn, June 3, Antibiotics.

**Burton J. Winston**, attending physician, St. Therese Hospital, Waukegan, June 10, The Arrhythmias.

**John M. Coleman**, clinical assistant in medicine, Stritch School of Medicine, June 17, on Anemia.

**Irvin S. Siglin**, assistant clinical professor of medicine, University of Illinois College of Medicine, June 24, on Obesity.

**Harley M. Sigmond**, associate in bone and joint surgery, Northwestern University Medical School, July 1, The Orthopedic Significance of Mild Unrecognized Poliomyelitis.

**Harry H. Boyle**, attending physician, Children's Memorial Hospital, July 8, The Tonsil and Adenoid Problem in Children.

**Linden J. Wallner**, clinical assistant professor of otolaryngology, University of Illinois College of Medicine, July 15, on Smoker's Larynx.

**Frederick Stenn**, lecturer in history, University of Illinois College of Medicine, July 29, Discovering Lost Gems in Medicine.

**Hans Von Leden**, assistant professor of otolaryngology, Northwestern University Medical School, July 22, on Hoarseness.

**William F. Cernock**, member of the department of medicine, Stritch School of Medicine of Loyola University, August 19, Hepatitis.

**Theodore Cornbleet**, clinical professor of dermatology, University of Illinois College of Medicine, August 26, Hygiene of the Skin.

**Elizabeth McGrew**, assistant pathologist, Research and Educational Hospitals, September 2, How the Pathologist Serves the Community.

**Peter J. Cotsirilos**, clinical instructor in pediatrics, Stritch School of Medicine of Loyola University, September 9, Nutritional Anemia in Children.

**John E. Kearns**, assistant professor of surgery, Northwestern University Medical School, September 23, The Diseased Thyroid Gland.

**"All About Baby" over WBKB, Channel 7.**— Since last publication, the following physicians have appeared on the telecast **"All About Baby"** over **WBKB, Channel 7**, under the auspices of the **Educational Committee** of the Illinois State Medical Society:

**Myron Hipkind**, associate clinical professor of otolaryngology, Stritch School of Medicine of Loyola University, May 26.

**Benjamin M. Kagan**, chairman, department of pediatrics, Michael Reese Hospital.

**Joseph A. Forbrich**, attending pediatrician, St. Anne's Hospital, June 9.

**Samuel Schweid**, attending physician, Cook County Children's Hospital, June 16.

**Edward S. Baxter**, attending pediatrician, MacNeal Memorial Hospital, Berwyn, June 23.

**Harry M. Levy**, member of pediatric staff, Michael Reese Hospital, June 30.

**William J. Corcoran**, attending pediatrician, Mercy Hospital, July 7.

**Samuel H. Barron**, assistant professor of pediatrics, University of Illinois College of Medicine, July 28.

**Aaron Grossman**, associate professor of pediatrics, Chicago Medical School, August 4.

**Joseph L. Earlywine**, member of the pediatric staff, Evanston Hospital, August 11.

**Irwin A. Halpert**, instructor in pediatrics, Chicago Medical School, August 18.

**Sol F. Ditkowsky**, assistant clinical professor of pediatrics, Stritch School of Medicine of Loyola University, August 25.

**Louis J. Halpern**, assistant professor of pediatrics, University of Illinois College of Medicine, September 1.

**Clarence J. Barasch**, member of the pediatric staff, Mount Sinai Hospital, September 8.

**Maurice L. Zee**, member of the pediatric staff, Grant Hospital, September 15.

**Adult Lecture Series** Arranged by the **Educational Committee** of the **Illinois State Medical Society.**—

**Leonard F. Jourdonais**, assistant professor of medicine, Northwestern University Medical School, on October 7 opened a series of lectures for the Waukegan Township Adult Evening School at the Waukegan Township High School, Waukegan, on Heart Disease. Other participants in the series, which was developed by the Educational Committee of the Illinois State Medical Society, include:

**Meyer Brown**, assistant professor of psychiatry and neurology, Northwestern University Medical School, October 14, on Mental Health.

**Danely P. Slaughter**, associate professor of surgery, departments of radiology and surgery, Uni-

versity of Illinois College of Medicine, October 21, Cancer.

**Charles I. Fisher**, instructor in medicine, Northwestern University Medical School, October 28, "Geriatrics" (Growing Old Gracefully).

**James I. Farrell**, assistant professor of urology, Northwestern University Medical School, November 4, on "The Male Climacteric" (Men Only).

**John R. Wolff**, assistant professor of obstetrics and gynecology, University of Illinois College of Medicine, November 18, "The Menopause" (Women Only).

**Lectures** Arranged Through the **Scientific Service Committee** of the Illinois State Medical Society:

**Burton C. Kilbourne**, Chicago, Henry County Medical Society, September 8, in Galva, on Surgical Aspects of Fractures.

**Edwin N. Irons**, Chicago, LaSalle County Medical Society, September 16, on Use and Abuse of Antibiotics.

**Edward L. Compere**, Chicago, Lee-Whiteside County Medical Societies, September 16, in Dixon, on Fractures of the Hip, Leg and Shoulder.

**R. Gordon Brown**, Chicago, Iroquois County Medical Society, September 21, in Watseka, on Radioactive Iodine.

**Thomas Masters**, Springfield, Macoupin-Montgomery County Medical Societies, September 28, in Carlinville, on Diabetes.

**William M. Lees**, Chicago, DeKalb County Medical Society in Sycamore, September 28, on Cancer of the Lung.

**Sanford A. Franzblau**, Chicago, Iroquois County Medical Society, October 19, in Watseka, on Geriatrics: The Principle of Adding Life to Years.

**John L. Reichert**, Chicago, Lee-Whiteside County Medical Societies in Dixon, October 21, on Unexpected Conditions in Infancy.

**C. Elliott Bell**, Decatur, Marion County Medical Society in Centralia, October 21, Present Status of Peptic Ulcer Treatment.

**Leon J. Unger**, Chicago, DeKalb County Medical Society in DeKalb, October 26, on Treatment of Bronchial Asthma.

**Burton J. Winston**, North Chicago, Henry County Medical Society in Galva, November 10, on Heart Failure.

**Charles N. Pease**, Chicago, Whiteside-Lee County Medical Societies in Dixon, November 18, on Children's Orthopedics.

**Alwin C. Rambar**, Highland Park, DeKalb County Medical Society in Sycamore, November 23, on Effect of Maternal Illness on the Fetus.

## DEATHS

**RALPH C. BROWN**, Winnetka, who graduated at Rush Medical College in 1904, died August 31, in Boston, aged 76. He was a member of the Illinois State Medical Society and professor emeritus in medicine at the University of Illinois College of Medicine.

EDWARD GRIFFITH DAVIS, Belvidere, who graduated at Bennett College of Eclectic Medicine and Surgery in 1900, and the College of Physicians and Surgeons of Chicago, School of Medicine of the University of Illinois in 1902, died June 19, aged 83. He was a member of the Illinois State Medical Society.

CHARLES HORACE DOWSETT, Watseka, who graduated at Northwestern University Medical School in 1908, died May 30, aged 72, of arteriosclerotic heart disease. He was a member of the Illinois State Medical Society, a past president and secretary of the Iroquois County Medical Society, and a member of the staff of the Iroquois Hospital.

ANFIN EGDAHL, Rockford, who graduated at Johns Hopkins University School of Medicine in 1904, died recently, aged 78. He was a member of the Illinois State Medical Society, a past president of the Winnebago County Medical Society and of the Winnebago County Tuberculosis Association, and at the time of his death, chairman of the Board of the Rockford Municipal Tuberculosis Sanatorium.

KURT PAUL FROELICH, Moline, who graduated at Medizinische Fakultät der Universität, Vienna, Austria, in 1933, died March 25, aged 45. He was a member of the Illinois State Medical Society.

EVERETT EDWARD HILL, Urbana, who graduated at Barnes Medical College, St. Louis, in 1906, died June 24, in the Burnham City Hospital, aged 77.

LEE TURNER HOYT, Roseville, who graduated at Rush Medical College in 1921, died June 16, aged 58, of coronary thrombosis. He was president of the Warren County Tuberculosis Association and chairman of the Warren County chapter of the National Foundation for Infantile Paralysis, and a member of the Illinois State Medical Society.

CHARLES M. JACOBS, retired, Winnetka, who graduated at Northwestern University Medical School in 1894, died September 11, aged 82. He was an emeritus

member of the Illinois State Medical Society and a former staff member of Cook County Hospital.

RICHARD J. MATTES, retired, Vandalia, who graduated at the Physio-Medical College of Indiana, Indianapolis, in 1896, died May 27, aged 87.

CLYDE SYLVESTER MCATEE, Fox Lake, who graduated at Northwestern University Medical School in 1921, died July 10, aged 62, of coronary disease. He was a member of the staff of the Veterans Administration Hospital, in Hines.

JOHN FRANKLIN REED, retired, Edinburg, who graduated at the Eclectic Medical Institute, Cincinnati, in 1899, died May 30, aged 89, of arteriosclerotic heart disease.

ROLAND O. SALA, Rock Island, who graduated at the State University of Iowa College of Medicine in 1924, died August 19, aged 54, of coronary heart disease. He was a member of the Illinois State Medical Society.

IRWIN G. SPIESMAN, Maywood, who graduated at the University of Illinois College of Medicine in 1922, died September 11, aged 58. He was a member of the Illinois State Medical Society and clinical assistant professor of otolaryngology at the University of Illinois.

LEONARD S. SZUMKOWSKI, Chicago, who graduated at the Chicago College of Medicine and Surgery in 1911, died September 11, aged 69. He was a member of the Illinois State Medical Society.

HUGH H. WEST, Elgin, who graduated at the Chicago Homeopathic Medical College in 1898 and at Harvey Medical College in 1900, died August 31, aged 84. He was a member of the "Fifty Year Club" of the Illinois State Medical Society.

ANNIE L. ZORGER, Waynesville, who graduated at American Medical College, St. Louis, in 1894, died May 28, aged 89, of chronic myocarditis and arteriosclerosis. She was a member of the Illinois State Medical Society.



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# BOOK REVIEWS



**THE ECZEMAS:—A SYMPOSIUM BY TEN AUTHORS.** edited by—L. J. A. Loewenthal, M. D. (L'Pool), M. R. C. P. (London), D. T. M. & H. (L'Pool) E. & S. Livingston Ltd. Edinburgh and London 1954. (The Williams and Wilkins Co., Baltimore)

This book contains 13 chapters and 2 appendices and includes the subjects of Contact Eczema; Allergic Eczema; Atopic Eczema; tables of concentrations and vehicles to be used for patch testing and prescriptions for basic therapy.

The chapters are well written and profusely illustrated. Each author presents his subject clearly. The authors give an histological definition of Eczema. On this basis, they make a distinction between contact dermatitis, allergic eczema and atopic eczema. The chapter on atopic dermatitis (eczema) is particularly well written and illustrated, and generally follows the principles accepted by American Allergists.

This book deserves to be in the libraries of dermatologists and allergists.

## BOOKS RECEIVED

The following books have been received for reviewing, and are herewith acknowledged. This listing should be considered as a sufficient return for the courtesy of the sender. Books that appear to be of unusual interest will be reviewed as space permits each month. Readers desiring additional information relative to books listed, may write the Editor who will gladly furnish same promptly.

**CLINICAL CHEMISTRY IN PRACTICAL MEDICINE.** By C. P. Stewart, D. Sc. (Dunelm.), Ph. D. (Edin.) Reader in Clinical Chemistry, University of Edinburgh, Senior Biochemist, Royal Infirmary, Edinburgh and D. M. Dunlop, B. A. (Oxon.), M. D., F. R. C. P. (Edin.), F. R. C. P. (Long.) Christison Professor of Therapeutics and Clinical Medicine, University of Edinburgh, Physician, Royal Infirmary, Edinburgh. Fourth Edition. E. & S. Livingstone LTD., Edinburgh and London, 1954. \$5.00.

**THE CONCEPT OF SCHIZOPHRENIA.** By W. F. McAuley, M. D., Belf., D. P. M., R. C. P. S. I., Principal Psychiatric Registrar, Downshire Hospital, Northern Ireland; Late Surgeon Lieutenant R. N. V. R., with a foreword by John H. Ewen, F. R. C. P., D. P. M., formerly physician and lecturer in psychological medicine at the Westminster Hospital. Philosophical Library, New York. \$3.75.

**DIAGNOSIS AND TREATMENT OF THE ACUTE PHASE OF POLIOMYELITIS AND ITS COMPLICATIONS.** Edited by Albert G. Bower, M.D., The Williams & Wilkins Company, Baltimore, 1954. \$6.50.

**DISEASES OF THE SKIN.** By Oliver S. Ormsby, M.D., Rush Professor of Dermatology Emeritus, University of Illinois; Attending Dermatologist to the Presbyterian Hospital of Chicago; and Hamilton Montgomery, M.D., M.S., Professor of Dermatology and Syphilology, Mayo Foundation for Medical Education and Research, Graduate School, University of Minnesota, Rochester, Minnesota; Consultant in Section of Dermatology and Syphilology, Mayo Clinic.

**TEXTBOOK OF PEDIATRICS.** By Waldon E. Nelson, M.D., Professor of Pediatrics, Temple University School of Medicine; Medical Director of Saint Christopher's Hospital for Children. With the collaboration of 70 contributors. Sixth Edition. 1581 pages. 478 figures. \$15.00.

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## HYDROCORTISONE IN RHEUMATIC DISEASE

Owing to the variable course of rheumatic disorders, response of patients to intra-articular injections must be evaluated with medications other than hydrocortisone. A suggestive element in injection therapy exists, coupled with the strong emotional support due to repeated close observation. Thirteen patients in this series, consisting of six with rheumatoid arthritis, four with osteoarthritis, two with periartthritis of the shoulder, and one with tenosynovitis of the fingers, received preliminary control injections, five with normal saline and nine with 1 per cent procaine. In three cases of rheumatoid arthritis, saline gave pain relief for a few hours in one, no relief in a second, and aggravation of pain in a third. In each of these, hydrocortisone, by contrast, produced analgesia lasting one week or more. One patient with severe osteoarthritis of the knee obtained consistent relief for one week with intra-articular hydrocortisone over a period

of four months. Substitution of saline, without patient's knowledge, caused a marked exacerbation of symptoms. Comparing the local effect of procaine hydrochloride and hydrocortisone in nine patients, it was observed that in no case receiving procaine did pain relief approximate the degree or duration of that achieved with hydrocortisone, nor did analgesia persist for more than a few hours, and that in four patients no analgesia at all was obtained. The trend of responsiveness to hydrocortisone contrasts sharply with these results. *Jacob Bornstein, M.D., et al. Geriatrics, May 1954.*

The sum of the achievements of tuberculosis associations may be measured not only in terms of tuberculosis control, but also in terms of the growth of many other public health services, including full-time health departments, clinic facilities, school health services, medical education and research, and industrial hygiene programs. *William P. Shepard, M.D., NTA Bulletin, May, 1954.*

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Personal communication (Apr. 12, 1950)

**1951** Of 119 patients treated with Azulfidine prior to 1944, 90 patients (75%) were symptom-free or considerably improved when re-examined in 1949.

Svartz, N.: *Acta. Med. Scandinav.* 141:172, 1951.

**1952** In a series of 52 patients with chronic ulcerative colitis 30, or 58%, showed significant improvement after treatment with Azulfidine.

Morrison, L. M.: *Gastroenterology* 21:133, 1952.

**1953** *Morrison* says: "Azopyrine [Azulfidine] . . . has been effective in controlling the disease in approximately two-thirds of patients who had previously failed to respond to standard colitis therapy currently in use."

Morrison, L. M.: *Rev. Gastroenterology* 20:744 (Oct.) 1953.

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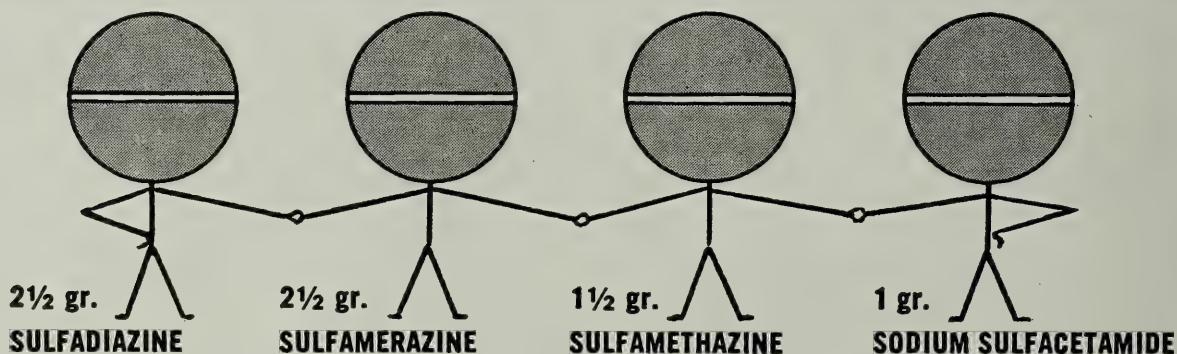
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From the study of 12 years' experience with electrosleep (shock) treatments at the De Paul Sanitarium and at Touro Infirmary (10,170 patients, receiving 74,275 treatments), it becomes apparent that this type of treatment is a tremendous boon in acute emotional and psychotic disorders. It is principally of value in treatment of emotional disorders, particularly the depressions. Individuals with depression, who received electrosleep therapy, were restored to normal or were well on the road to recovery within 26 days. Similar cases 15 years ago, who did not receive electrosleep therapy, required 126 days for recovery. Electrosleep therapy greatly shortens the period of hospitalization and prevents suicides. Patients are promptly relieved of their great mental suffering, soon sleep with little or no sedation, and they gain weight. Psychotherapy often is very difficult to carry out in the depressed, agitated, or manic patient but after electrosleep therapy, they can be benefited by psychotherapy.

Complications are comparatively few and there have been no fatalities caused by electrosleep treatment in this group of 10,170 patients. *Charles S. Holbrook, M.D., J. Louisiana M.A., Jan. 1954.*

Tuberculosis continues to be the number one cause of serious illness from communicable disease. We have seen an ever-increasing case load in tuberculosis and the seriousness of the problem is best measured by case rate and prevalence instead of mortality rate. In consequence, it is the consensus of this group that all services of case finding, diagnosis, case holding, treatment, financial aid and case work, and rehabilitation (including vocational rehabilitation) be expanded instead of curtailed and that the public be so informed of these facts. (Resolution signed by 18 health officers from Florida and Georgia who were in attendance at a short course for health officers in tuberculosis arranged by the state health departments of Florida and Georgia.) *ATS News Letter, May, 1954.*



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acid vaginal douche

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Massengill Powder in the standard solution has a pH of 3.5 to 4.5, approximating the acidity of the normal, healthy vagina.

Massengill Powder solution provides a vaginal douche that is cleansing, soothing, deodorizing, and highly useful as an adjunct in the treatment of many pathological conditions of the vaginal tract producing leukorrhea. Because the solution is nonirritating, it can be used for routine feminine hygiene. Its clean, refreshing odor makes Massengill Powder acceptable to the most fastidious patient.

Massengill Powder contains: Boric Acid, Ammonium Alum, Berberine Salt, Phenol, Menthol Isomers, Thymol, Eucalyptol and Aromatics.

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**GENEROUS SAMPLE  
ON REQUEST**

## AMEBIC ABSCESS OF LIVER

Colonel Ryle A. Radke, M.C., reported clinical data on 15 cases of amebic hepatic abscess. The following diagnostic criteria were used:

1. The presence of the clinical syndrome of amebiasis.
2. Demonstration of intestinal lesions by sigmoidoscopic technics, or demonstration of *E. histolytica* in aspirations or stool.
3. Objective evidence of focal hepatic involvement.
4. Unequivocal response to appropriate therapy.

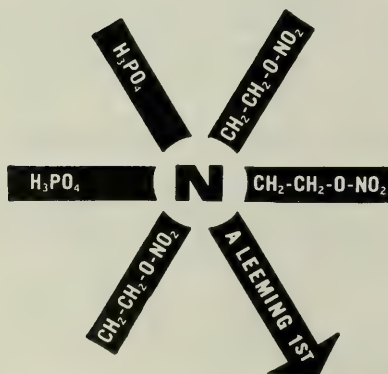
Twelve of the cases complained of sharply localized hepatic pain and examination disclosed this area to be the area of maximal tenderness. In all cases the pain was sharp and radiated to the clavicle. Enlarged liver and loss of weight were present in all case. Elevation of the diaphragm was present in 10 cases, and an abdominal mass was palpable in three and demonstrated by x-ray and surgery in one additional case each. All were successfully treated with Atabrine and Carbarsone, surgical incision being required in

two cases and thoracentesis in two cases. One carcinoma. *Ryle A. Radke, Col. M.C., DIAGNOSIS AND TREATMENT OF AMEBIC LIVER ABSCESS. Ann. Int. Med., May 1954.*

## EARLY LUNG CANCER

Doctors have been thrown a challenge. The widespread use of x-ray screening has focused attention upon the early detection of silent lung disease. The discovery of an abnormal area of density in the lung field alerts the individual. The physician and patient are brought into contact, and responsibility is immediately shifted. The cancer potential of every silent shadow must be estimated and promptly so. The challenge of the survey film will be remembered by both patients and relatives. Months or years later, when time has permitted progression to an unresectable lesion, almost inevitably the question is asked, "But why were we not advised that it might be so serious when the shadow was first found?" *Richard H. Overholt, M.D., M.A. Alabama, April 1954.*

# Angina pectoris prevention



The new strategy in angina pectoris is prevention, the new low-dose, long-acting drug—METAMINE. Most effective milligram for milligram, and better tolerated, METAMINE prevents attacks or greatly diminishes their number and severity. *Dosage:* 1 tablet (2 mg.) after each meal; 1-2 tablets at bedtime.

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the meal-time behavior problem, the child who shreds his mother's patience and  
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to stimulate appetite . . . to promote growth . . .

*prescribe* **TROPHITE\***

B<sub>12</sub> plus B<sub>1</sub>

Each 'Trophite' Tablet or teaspoonful of liquid 'Trophite' provides:

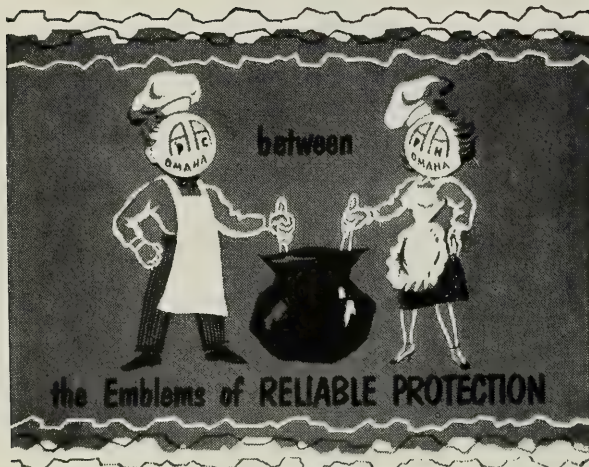
25 mcg. of vitamin B<sub>12</sub>

10 mg. of vitamin B<sub>1</sub>

\*T.M. Reg. U.S. Pat. Off.

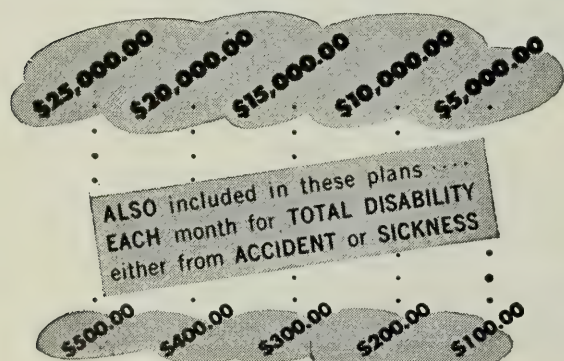
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## IMMUNIZATION SCHEDULE FOR AMERICAN TROOPS

Army troops throughout the world will be immunized against influenza in accordance with a new tri-service policy, it was announced by Major General George E. Armstrong, Army Surgeon General.

All Army troops will be administered the vaccine prior to a November 15 deadline before the onset of the usual winter respiratory diseases. Troops entering the Army after November 15 will be given the vaccine as soon as possible after induction, according to the announcement.

The new policy regarding immunization against influenza has been agreed upon by the Surgeons General of the Army, Navy and Air Force.

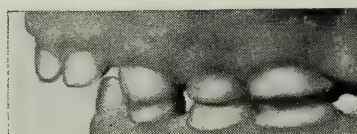
Last year, only Army troops in overseas commands were given vaccine for influenza. In years before, Army-wide immunization was administered after the first cases of the respiratory disease were detected and identified. Using this system, it was not always possible to provide vaccine to protect all troops before the beginning of the season.

But this year, according to General Armstrong, the Army will immunize all troops before the first outbreaks using a modified vaccine incorporating a recently isolated virus strain.

"Experience has shown", said General Armstrong, "that effective individual and group protection afforded by immunization with influenza vaccine can be expected only when the vaccine is given in advance of the usual respiratory disease season."

## THUMBSUCKING

since infancy caused this malocclusion.



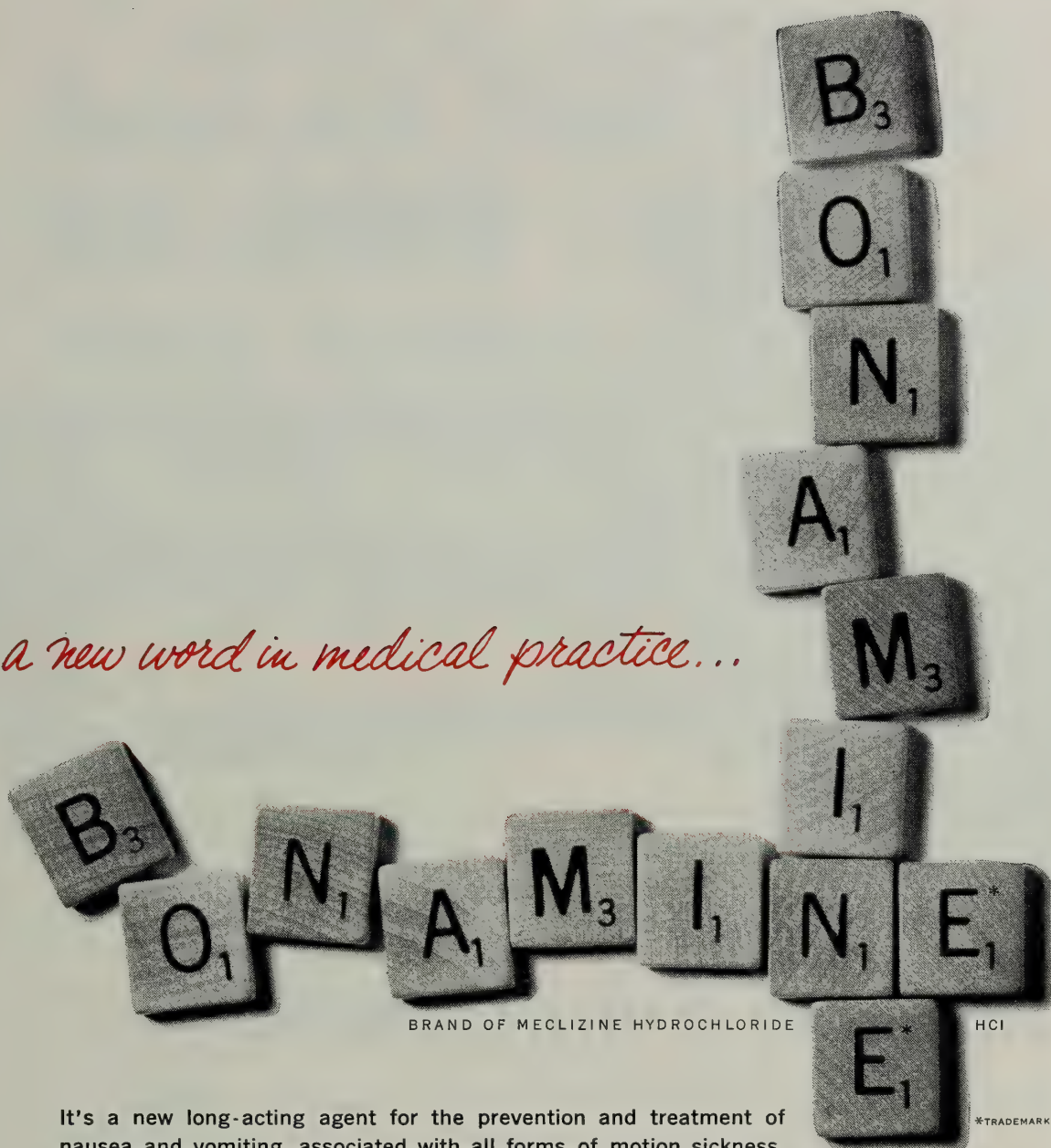
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It's a new long-acting agent for the prevention and treatment of nausea and vomiting, associated with all forms of motion sickness, radiation therapy, vestibular and labyrinthine disturbances, and Ménière's syndrome.

Side effects, so often associated with the use of earlier remedies, are minimal with Bonamine. Its duration of action is so prolonged that often a single daily dose is sufficient. Bonamine is supplied in scored, tasteless 25 mg. tablets, boxes of eight individually foil-wrapped and bottles of 100.



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## COST OF MEDICAL EDUCATION

The public is thoroughly indoctrinated with the idea that medical schools and medical education are very expensive. One hundred and six million dollars, the sum expended by all medical schools in 1950, is considered a large sum for the support of one form of professional education. However, the Survey data reveal that medical schools are unique in the university family of schools, in that the education of the physician is only one of its many educational responsibilities. In addition to education, the 106 million dollars supports research and services which are of tremendous value. Medical school costs actually are very low in comparison to the value of their products. One hundred and six million dollars is only 8.2 per cent as much as the nation spent on jewelry, or 1.3 per cent of the sum spent on alcoholic beverages in 1949. There is little doubt that not only can the public afford to support the medical schools as they exist today but they can well afford to greatly increase their support. The medical schools have not informed the people

of the value of their activities. Until this is done, intelligent support cannot be expected. *John E. Deitrick, M.D. and Robert C. Berson, M.D., McGraw-Hill, 1953.*

It seems apparent that the general practitioner is going to be involved in the actual treatment of the tuberculosis patient to a much greater extent than he has in the recent past and fewer patients will be treated by specialists in chest diseases. Another factor acting in the same direction is the relatively shorter time that the average patient will spend in a hospital and the fact that such hospitalization is less likely to be in a remote institution. The family physician, therefore, will be less likely to lose supervision of his patient. This trend requires a change in the nature and emphasis of postgraduate medical conferences and courses of instruction, which must be directed more toward the general practitioner. *James E. Perkins, M.D., NTA Bulletin, May, 1954.*

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the tiny **New Maico**  
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Often a doctor will encounter certain difficulty in diagnosing cardiac, chest and foetal heart conditions because the most important sounds to the diagnosis are too faint to be judged by means of the ordinary stethoscope. Many such sounds occur in the lower frequency ranges, where normal hearing has its poorest sensitivity.

Through utilization of the new principle of all-transistor instruments, the Maico engineering staff has developed a powerful yet small precision electronic stethoscope, the use of which will help the doctor to identify heart sounds he ordinarily couldn't even hear with the usual instrument.

## How the Maico Stethetron Assists You

It provides *selective* amplification, enabling the physician to give powerful amplification to frequency ranges which include the sounds he wishes to hear, and comparatively little amplification to the frequencies in which he is not interested at the moment.

## Amplifies Sounds Below Normal Threshold

The Stethetron not only amplifies sounds normally heard with the acoustic stethoscope, but also makes it possible to hear clearly sounds which would be inaudible to even the sharpest ears with any other method of auscultation.

## Helpful to All Physicians

The Maico Stethetron was *not* designed primarily for physicians who are hard of hearing. It can and does give daily assistance to physicians who have hearing impairments, but its fundamental purpose is to help overcome obstacles which every physician encounters in his *everyday* auscultation.

## What Cardiologists and General Physicians Say:

"Brings out distant heart tones very well in fleshy, obese persons."

"Is exceptionally well adjusted to picking up heart sounds and chest sounds in a room where other people are present, since it is a contact type of microphone and one gets no extraneous sounds."

"Have used the Stethetron in picking up the continuous murmur which results from a shunt operation for the correction of 'blue babies'. With the instrument, I have been able to hear it before I could without the instrument, and this is a great comfort to the parents because it means a successful operation."

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So that you may more readily understand what this astonishing instrument really is and what it does, we'd like to show you something you've never experienced *before in a laboratory or in your practice*. We will reproduce the exact sound, tone and intensity of a human heart murmur through a newly-developed electronic instrument, right in your own office. And we will show you how the Maico Stethetron clearly picks up heart murmurs so faint you can't hear them through your own acoustic stethoscope. Just mail the coupon for an appointment.

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Oxytetracycline hydrochloride (Terramycin) (3 per cent) with polymyxin sulfate B (0.1 per cent) topical ointment has been used in over 200 cases of skin infections, with unusually favorable and prompt results in a number of conditions. Not one case of irritation or sensitization was encountered, even though the patients were in the widest range of age from infancy on. The ointment was prescribed to be used in the usual and ordinary manner by applying it to the affected areas three times a day. If the condition was excessively crusted, the crusts were to be washed off with one of the usual dermatologic type of soapless detergents. No unusual ritual was required, and no other supplementary treatment was used. The effectiveness was most striking in the pyogenic dermatoses: 21 cases of impetigo; 18 cases of folliculitis (scalp and beard, except one of axillae); 54 cases of impetiginized dermatoses (including 10 cases of neurodermatitis); 20 cases of dermatitis venenata; eight cases of seborrheic dermatitis; four cases of hypostatic dermatitis (varicose eczema) and varicose ulcer; and 12 miscellaneous dermatoses. Five case of otitis externa (infectious eczematoid dermatitis), which ranged in duration from one to five months, cleared up in from three to five days. Five cases of acne necrotica miliaris of the scalp, which ranged in duration from five months to three years, cleared up in from three to eight weeks. *Bernard Apple, M.D. Am. Pract. May 1954.*

## ARTERIOSCLEROSIS IN A DAY

It is no longer reasonable to accept the view that arterio-sclerosis is synonymous with aging. There is a growing body of evidence that arterio-sclerosis may occur in a series of disconnected episodes. Russell Holman has emphasized this by stating that atherosclerosis may be a disorder of "days not decades." It is quite possible that brief, repeated insults such as infections, brief periods of disease, intense emotional upsets, or other factors that sharply alter the form in which circulating cholesterol is carried may be responsible for the episodic occurrence of atherosclerosis rather than its continuous development throughout the life span of the individual. *Campbell Moses, M.D. Postgrad Med., May 1954.*

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In weight reduction management Rauwidrine proves particularly advantageous. The appetite-suppressing effect of the amphetamine component can be maintained for long periods, since side actions are obviated.

**DOSAGE:** *For mood elevation*, one to two tablets, each before breakfast and lunch. Dosage should be individualized, and as much as 6 tablets per day (in 3 doses) may be given if needed.

*For obesity*, one to two tablets 30 to 60 minutes before each meal.

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An old Scot, suffering from hunger pain, was advised by his doctor to be x-rayed. Told that this would cost him ten guineas, he asked what a consultation with a physician would cost. "Five," was the reply. The choice was clear. Examination revealed a mouthful of septic teeth, a much too liberal allowance of the spirits of his country, and pipes that never were cleaned. He was given a two months' probation from radiology on condition that these matters were attended to. At the end of this time Mr. Mackenzie reported to his doctor that he was cured. "But I want to see that consultant again," said the Scot. "It will cost you another three guineas." "Ah, weel, I want to see him." "But I hear from your doctor that you have lost your indigestion," I said when he arrived. "Yest, doctor, I am a weel man; that must have been a very powerful drug that you ordered for me." (My note told me it had been sod. bic.) "Well drugs are powerful according to wheather they do their job or not." "Yes, doctor, but winna me body have to pay for it?" Assurance on this point was worth

three guineas and the patient was still two guineas up on the whole transaction. *Lord Horder, M.D., What Is Indigestion? Practitioner, Jan. 1953.*

## **CANCER TESTS**

Tagged colchicine, a drug derived from plants grown at the university's atomic farm is useful in showing chemical differences between cancer patients and normal individuals, according to a report made by Edward J. Walaszek, fellow of the National Cancer Institution, to the Federation of American Societies for Experimental Biology, April 14 in Atlantic City. The colchicine was derived from the autumn crocus, grown in airtight greenhouses containing radioactive Carbon 14 in the form of carbon dioxide. In cancer patients, only 0.2 to 6 per cent of the colchicine was excreted in an unchanged form, while the range in noncancer patients was from 15 to 50 per cent. *College Briefs. J. Med Education, May 1954.*

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# VAGINAL ANATOMY AND CONCEPTION CONTROL

Another observation based on  
425 patient years of exposure

According to a recent comparative study by Guttmacher and co-workers,<sup>1</sup> vaginal anatomy and parity apparently play important roles in the selection of a contraceptive method. Using the jelly-alone method, they found that markedly greater protection was afforded to women of low parity, and suggested that the jelly "might be confined to the region of the external os more successfully in the less relaxed vagina."

Of 325 women who used the jelly-alone [RAMSES® VAGINAL JELLY] technic for periods ranging from three months to three years, 36 percent were primiparous. The statistically valid data, based on 425 patient years of exposure, definitely indicate that the jelly-alone method of contraception was considerably more effective "among patients of lower parity."

The use of jelly alone as a contraceptive measure proved highly successful in the entire group, and only a few unplanned pregnancies occurred. These were either considered as (1) patient failures, comprising those instances in which the patient admitted complete omission or irregular use of the jelly, or as (2) method failures, where the patient claimed regular and careful use of the jelly.

The total unplanned pregnancy rate averaged only 16.7 per 100 patient years of exposure. If method failures alone

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It is apparent from this study that RAMSES VAGINAL JELLY is markedly effective in the jelly-alone technic, and that it is a "method of choice" for most nulliparous and primiparous patients.

Anatomic considerations, however, should not be the sole criteria used in the selection of a contraceptive method. Such factors as patient intelligence and cooperation, as well as the sincere desire for conception control, are also of paramount importance. Thus, the choice of method must, in the end, depend upon the physician's evaluation of the individual patient.

When in the judgment of the physician, parity, anatomic factors, or motivation indicates the use of the diaphragm-and-jelly method of contraception, the RAMSES® TUK-A-WAY® Kit is recommended. The RAMSES® diaphragm is flexible and cushioned — providing an optimum barrier with utmost comfort. In combination with RAMSES jelly, it offers an unsurpassed contraceptive technic — and both products are **accepted by the appropriate Councils** of the American Medical Association.

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425 EXPOSURE YEARS	425 EXPOSURE YEARS
TOTAL FAILURE RATE	METHOD FAILURE RATE
16.7	10.82

Effectiveness of RAMSES VAGINAL JELLY as contraceptive measure in 325 patients during 425 patient exposure years<sup>1</sup>

\*Active agent, dodecaethyleneglycol monolaurate 5%, in a base of long-lasting barrier effectiveness.

1. Finkelstein, R.; Guttmacher, A., and Goldberg, R.: Am. J. Obst. & Gynec. 63:664, Mar., 1952.

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Wounds heal by scar and the healing process starts immediately after the wound is incurred. During the first few days the healing tissues are simply an unorganized exudate. Soon this is penetrated by capillaries and granulation tissue forms and continues to form until the wound closes. If, to the mere fact of remaining open, is added further irritation in the form of bacteria or chemical antiseptics, the granulations become increasingly exuberant and, as they form, the deeper layers become organized into dense scar. Not until the surface is covered with epithelium does the formation of granulation tissue cease. Hence, the longer the wound remains open, the greater the amount of scar tissue, the more the impairment of function from this factor, and the greater the difficulty if secondary repairs are required. Scars of moderate extent are of little significance in some areas of the body. On the other hand, even tiny scars, may cause limitation of function. *Michael L. Mason, M.D., Postgrad. Med., April 1954.*

### CORD STRIPPING

A study of four technics of cord clamping and their effect on the blood of 100 normally delivered infants is presented. Cord stripping is considered the most efficacious method of improving the infant's blood picture, with delayed clamping next in preference. Immediate clamping, by far the worst method, deprives the infant of blood. Cord clamping apparently has no influence on the weight or general well being of the normal infant delivered without obstetric complications. Such an infant can adjust itself adequately to a moderate anemia. Conversely, it is apparently no better off, at least clinically, with an increased amount of blood. Cord stripping or delayed cord clamping or both are urged to effect a maximum placental transfusion in infants who are shocked after a traumatic delivery, anemic after a bleeding accident before or during birth, delivered by cesarean section, or born prematurely. *Anthony E. Colozzi, M.D., New England J. Med. Apr. 15, 1954.*

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Rauwolfia  
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\*

Wilkins, R. W.; Judson, W. E.; Stone, R. W.;  
Hollander, William; Huckabee, W. E., and  
Friedman, I. H.: Reserpine in the Treatment  
of Hypertension: A Note on the Relative  
Dosage and Effects, New England J. Med.  
250:477 (March 18) 1954.

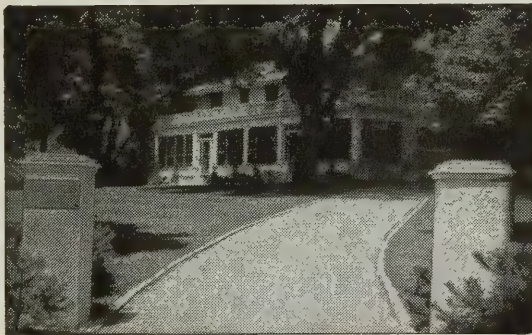
Increasing experience continues to show that *Rauwolfia serpentina* is as basic in essential hypertension as digitalis is in congestive heart failure. Furthermore, recent evidence\* demonstrates that reserpine possesses the unique anti-hypertensive, sedative, and bradycrotic properties characteristic of this unusual drug. On the basis of this study, reserpine is regarded by these investigators as the chief active principle of *Rauwolfia serpentina*.

Crystoserpine—reserpine, Dorsey—is valuable in all grades of essential hypertension. In the milder forms and in labile hypertension, it usually suffices alone. In the more severe forms, it reduces the amounts required of more potent antihypertensive agents.

In addition to lowering the blood pressure through central action, Crystoserpine induces a state of calm tranquility. Emotional tension is eased, the outlook improved.

There are no known contraindications to Crystoserpine. Average dose, 0.25 mg. to 1.0 mg. daily. Supplied in 0.25 mg. scored tablets.

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1. Klohs, M. W.; Draper, M. D., and Keller, F.: J. Am. Chem. Soc. 76:2843 (May 20) 1954.

2. Cronheim, G.; Brown, W.; Cawthorne, J.; Toekes, M. I., and Ungari, J.: Proc. Soc. Exper. Biol. & Med. 86:110 (May) 1954.

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Symptoms of poisoning from any organic phosphate insecticide (HETP, TEPP, parathion) are treated with atropine. This procedure should be supplemented with gastric lavage or, if the material gets into the eyes, ocular irrigation. The recommended dose of atropine is 2 mg. intramuscularly at hourly intervals or more frequently if necessary until the patient has become atropinized. Morphine is contraindicated as it depresses circulation. The administration of oxygen and artificial respiration also may be necessary auxiliary measures.

If insecticides are to be used safely, there are certain precautionary measures which must be adhered to strictly. Persons employing insecticides in the form of dusts, sprays, mists, and aerosols must avoid excessive inhalation of the material. Operators engaged in the large scale application of any of these formulations should wear respirators and other protective devices. Measures should be taken to keep the material out of the eyes and mouth. When solutions or emulsions are used, particularly concentrates,

every effort should be made to prevent them from contacting the skin. Material which is spilled on the skin should be washed off immediately with soap and water. When solutions or emulsions are spilled on the clothing, the garments should be changed. Workers involved in the mixing of these materials, particularly concentrates, should wear respirators, goggles, and solvent resistant gloves, aprons, and boots. This work should be done in a well ventilated room, and fire precautions should be taken with inflammable solvents. Personnel such as pilots who are working with or engaged in the routine application of organic phosphate compounds should wear full face masks as well as respirators. Furthermore, they should undergo periodic tests to determine cholinesterase levels. If cholinesterase activity is reduced significantly, these persons should be removed from further exposure until such time as this enzyme resumes a normal level. *Don W. Micks, Sc. D., Potential Health Hazards of Organic Insecticides. Texas J. Med. March 1954.*

It would be highly gratifying intellectually to have it said that our attack on the problem of specific chemotherapy of tuberculosis was based on a comprehensive and astute understanding of the physiologic chemistry of the tubercle bacillus. Unfortunately, such was not the case. Instead our approach was similar to that of countless others: a formula consisting largely of enthusiasm, hope, faith, persistence, and luck. Perhaps the latter was the most important ingredient. *William H. Feldman, D. V. M., Am. Rev. Tuberc., June, 1954.*



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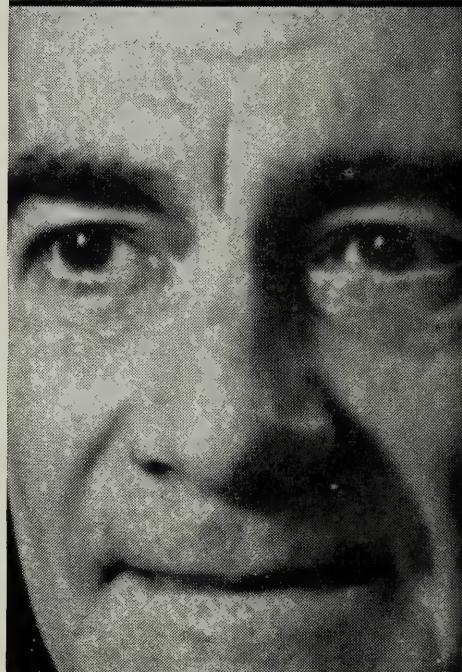
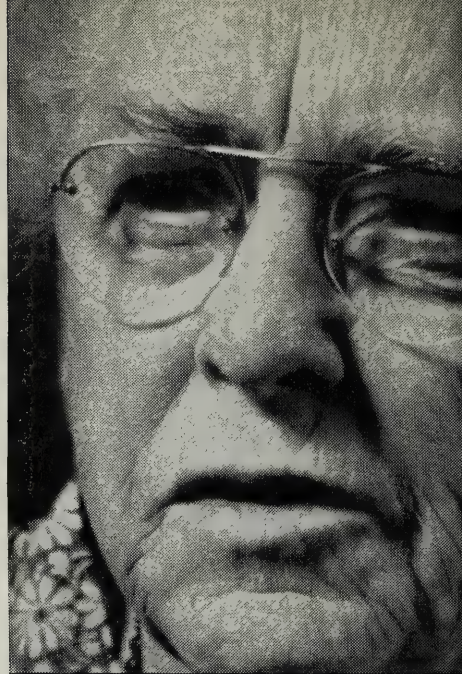
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# *The* **ILLINOIS** *Medical Journal*

**Official Journal of the Illinois State Medical Society**

**Harold M. Camp, EDITOR.**

**Theodore R. Van Dellen, ASSOCIATE EDITOR.**

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## **The Cancer Ulcer Problem of the Stomach**

**J. Dewey Bisgard, M.D.  
Omaha, Nebraska**

The proper and aggressive approach to the early diagnosis and treatment of cancer of the stomach has not received the attention it deserves. This, I believe, is the result of an attitude of futility in the minds of many physicians in respect to gastric carcinoma. Cancer of the stomach like cancer of other organs at one time is a local lesion confined to the stomach and curable by resection but at some minute of some day it disseminates and only too often to tissues and organs which are not expendable.

Unfortunately, there is a sizable group, probably comprising as much as a fourth of all the cases, which is incurable from metastases, before symptoms appear or at least before there is sufficient distress to lead to medical consultation. Almost without exception cases in this group have died of cancer in spite of heroic efforts to circumvent the disease by extending resection to include such procedures as pancreatectomy and partial hepatectomy.

In the majority of cases, however, it would appear that symptoms develop quite early and that there is an unnecessarily long delay in the interval between the onset of symptoms and the correct diagnosis. This delay has been attributed too generously to the patient's indifference to his symptoms and reluctance to consult a physician. Unfortunately, the evidence often also incriminates the medical profession. This is attributable

to certain misconceptions regarding the disease.

Some misunderstanding results from the unfortunate use of the term, "peptic ulcer." This is unfortunate because it conveys the impression that ulcers of the duodenum and ulcers of the stomach are identical lesions. From a clinical point of view there is one very important difference. Ulcerating lesions of the duodenum, almost without exception are benign and do not present an urgent problem in differential diagnosis as do ulcerating lesions of the stomach where cancer is common. More important is the fact that the textbook description of cancer of the stomach is not the early picture of the disease and the one in which we are most interested, but rather the late picture. For this reason, there is not sufficient awareness of the fact that the early symptoms of cancer of the stomach in at least one third of the cases are identical to those of benign ulcer of the stomach and that despite every available means of diagnosis it is impossible in a large percentage of cases to differentiate early carcinoma from benign ulcer.

This fact and its importance in respect to early diagnosis and treatment has been brought out in several publications. From a study of two thousand four hundred and sixty-nine cases of carcinoma of the stomach Walters, Gray and Priestley found that thirty-seven per cent of the patients who had operable carcinomas of the stomach and twenty-five per cent of patients with inoperable lesions gave histories that were typical of benign ulcer, and, furthermore, the dis-

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**The Oration in Surgery presented at the Annual Meeting, Illinois State Med. Society, Chicago, May, 1954.**

troubling fact that eighty per cent of the patients with carcinoma of the stomach who gave typical ulcer histories gained temporary relief of symptoms from medical management. Unfortunately, relief on an ulcer regimen is often interpreted by both the physician and patient as confirmatory evidence of the benign character of the lesion, with the result that definitive treatment is delayed and the patient's chance of cure correspondingly reduced. The patient relieved of distress is likely to disregard instructions to return for follow-up observation until symptoms recur.

In the same series of cases these authors found that by x-ray study the diagnostic error was reduced to ten per cent; that is, in ten per cent of the cases the roentgenologists diagnosed carcinomatous lesions as benign ulcers. In an additional fourteen per cent of cases they stated that the diagnosis was indeterminate.

Similarly, Allen and Welch reported two hundred and seventy-seven cases which had been diagnosed and treated as gastric ulcers at the Massachusetts General Hospital. In this series there were thirty-nine cases in which the ulcers subsequently were proved to be carcinomatous, an error of fourteen per cent.

The advantage to be gained from resecting carcinomas when they are indistinguishable from benign ulcers is brought out by Allen and Welch. In a series of thirty cases in which the preoperative diagnosis was benign ulcer but in which the resected specimens proved to be carcinoma, forty per cent was living and well five years after operation. These results were compared with those obtained in ninety-three cases in which resections were done for lesions which were obviously carcinoma preoperatively. Only twenty per cent of this series was living and well at the end of five years.

As has been pointed out recently, patients with long histories have a better post-operative prognosis, but it is reasonable to assume that this same group would have a still better prognosis from earlier operations.

How is it possible to salvage by early resection this sizable group of cases which masquerades as benign ulcer? To reach the largest number of cases at the earliest and most favorable time would necessitate resection of all ulcerating lesions of the stomach.

Obviously, the application of this principle would result in the resection of many uncomplicated benign ulcers, but this is acceptable on the basis that benign, gastric ulcers as a group are better treated by resection. Furthermore, if some of the carcinomas arise in chronic benign ulcers then resection of ulcers may, on occasion, have prophylactic merit.

A more conservative but less certain and less expeditious method is that of clinical trial. By this method all questionable cases are placed on a rigid ulcer regimen, for a period of three weeks. At the end of this time all patients who fail to obtain relief should be resected without delay. Certain of these refractory cases are benign ulcers but are sufficiently intractable to necessitate resection. All remaining patients, without exception and irrespective of relief of symptoms, should be re-examined roentgenographically. The patient must be impressed with the necessity of re-examination and with the fact that relief of symptoms on an ulcer regimen does not preclude the possibility of a malignant tumor. Carcinoma can be excluded with certainty only by evidence of progressive and final healing of the lesion in serial roentgenographic studies. It is not enough to demonstrate merely a reduction in the size of a crater but it is obligatory to carry out roentgenographic examinations every 2 weeks thereafter, until all evidence of the ulcer crater has disappeared. An ulcer regimen may cause a reduction in the inflammatory reaction around a carcinomatous ulcer and create the illusion that the crater has become more shallow and smaller.

It goes without saying that all lesions which fail to regress or fail to heal after an initial regression should be resected.

Various criteria have been offered to aid in the differential diagnosis of ulcer and carcinoma, such as the age of the patient, the duration of symptoms in respect to the patient's age, the location the lesion in the stomach, the size of the crater and gastric acidity. Unfortunately, there are too many exceptions to each of these criteria to be relied upon in making a vital decision in the individual case. This problem can be decided on no less precise evidence than that provided by biopsy and, until tissue can be obtained by other means, it will be necessary to continue explora-

tory operations. The recovery and identification of cancer cells by indirect methods is helpful only in the positive. Failure to recover cancer cells has no significance; it does not rule out cancer.

In summary, it may be stated that the prevailing defeatist attitude in respect to carcinoma of the stomach is unwarranted. To be sure, there is a minority group of cases which from the beginning are hopeless. The tumors in this group metastasize early and, presumably before the local lesion gives rise to symptoms. Of the other

cases the majority reach the surgeon several months or even years after the onset of symptoms. Most of them have been treated as peptic ulcers or as achlorhydric or other forms of dyspepsia and in many instances treatment has been administered without recourse to roentgenographic investigation. In addition to and included in this group are the cases in which every available means of investigation short of exploration fails to differentiate the malignant from the benign ulcer.

1420 Medical Arts Bldg.

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## Industrial Dermatitis

**Leonard F. Weber, M.D.**  
**Chicago**

The Committee on Industrial Health of the Illinois State Medical Society wishes to advance the practice of industrial medicine. Physicians are aware that industrial medicine is a necessity in more communities since the trend toward decentralization of industry. A recent poll of the members of the American Academy of General Practice shows that about 93% of its members are interested, more or less, in industrial medicine. By reason of this expression, an educational program of industrial diseases should include the common disease of industrial dermatitis.

The subject of industrial medicine is of economic importance to both physicians and employers. The National Association of Manufacturers' study of industrial medicine involving some 3,500 companies reveals that plants can expect the following savings as a result of setting up medical departments: a 44% drop in accident frequency; a 46% drop in occupational diseases; a 29% drop in labor turnover; a 39% drop in absenteeism; a 30% drop in compensation insurance premiums. A decrease in industrial dermatoses follows inspection and investigation of manufacturing plants by physicians interested in industrial dermatology because management learns of unsuspected hazards.

Dermatosis (pl.-oses) is any disease of the skin and dermatitis is inflammation of the skin.

Dermatitis, regardless of the causative agent, is characterized by the classical symptoms of redness, increased heat, swelling, and pain. Contact dermatitis caused by external exposure to industrial irritants during the course of the employee's work is industrial dermatitis.

### INCIDENCE

About two-thirds of all occupational diseases are industrial dermatoses. According to the U. S. Public Health Service, more than one percent of employees engaged in various industries suffer sometime during the year with industrial dermatitis. One may estimate that one-half million persons are affected with a disease of the skin due to industrial work and most of them are not reported to compensation boards because they are not incapacitated.

### INDUSTRIAL DISEASES VS. NON-INDUSTRIAL DISEASES

Contact dermatitis is common because the skin is the largest and first organ of the body to come in contact with cutaneous irritants, and they are legion. This may lead to the fanciful notion that dermatitis on the hands is always due to industrial work simply because the patient is employed in a manufacturing plant. Insistence upon industrial exposure as a cause of disease, without exhaustion of other possi-

bilities, occurs in other branches of medicine nowadays. For instance, diseases of the lung are attributed to industrial exposure if the patient is employed in industrial work. Occasional mistakes in etiology and diagnosis of industrial diseases are understandable. More attention, however, to industrial diseases in our present day medical schools would reduce these misunderstandings.

#### CAUSES

The causes of industrial dermatitis are predisposing and actual. The presence of other cutaneous diseases predisposes to industrial dermatitis and it is advisable to reject applicants with cutaneous disease for employment in occupations notorious for industrial irritants.

The actual causes of industrial dermatitis are many. The continued growth of industry and the development of new materials add new and old hazards to the list of causal agents. The actual causes are due to either a primary irritant (non-sensitizer) or a sensitizer.

#### REPORT OF INDUSTRIAL DERMATITIS

Name of patient:                      Date:  
 Address:                                      Age:  
 Occupation:                              M. S. Wid.  
 Employer:                              Address of employer:  
 Chief complaint:  
 Detailed story of accident or disease (Patient's own words):

#### History:

General health:  
 Previous skin disease or diseases:  
 Present industrial:  
     Duration:  
     Sites in order of involvement:  
     Objective symptoms (stripped examination):  
     Treatment:  
     Stopped work (date):

#### Work:

1. Previous occupations:
2. How long with present firm:
3. Duration of present job:
4. Details of process:
5. Substances handled:  
     Known cutaneous irritants:
6. Cleansing process at factory and home:
7. Changes in process, in substances, in cleansing:
8. Other individuals affected:
9. Work outside of regular employment:

10. Regular work:

11. Hobbies:

*Diagnosis: Opinion: Cause:* (Primary irritants or sensitizers)

1. Industrial dermatitis: Definite:
  - History
  - Exposure or injury
  - Attacks on exposure
  - Amelioration
  - No outside irritant
  - Examination lesions are consistent
  - No evidence of other skin disease
2. Industrial dermatitis: Probable:
  - Relation less clearcut
  - Substance less often causing irritation
  - Lesions less characteristic
  - Condition nearly well
3. Industrial dermatitis: Possible:
  - Substances seldom causing irritation
  - Other possible irritants
  - Lesions more indefinite
  - Other possible diagnosis
4. Not industrial dermatitis:
  - Definite evidence of other cutaneous diseases

*Criteria* are difficult to apply in certain cases:

1. If there is sensitization;
2. If there is accentuation of existing cutaneous disease because of occupational factors;
3. If there are supervening complications of other dermatoses and industrial dermatoses;
4. If considerable time has elapsed between the onset of dermatosis and examination;
5. If there has been overtreatment.

#### PRIMARY IRRITANT DERMATITIS

Almost 80 percent of all industrial dermatitides are caused by primary irritants. A primary irritant causes dermatitis by direct action on the normal human skin at the site of contact if it is of sufficient intensity for a sufficient time.

Every sunworshipper knows that exposure to the sun during the summer for a sufficient time causes solar dermatitis. There are other physical causes, such as heat, cold, electricity, x-rays, and radium. X-ray burns among physicians are a problem even today. Of more importance is the introduction of x-rays into industry to detect

defects in metal, and burns from this source are not a rarity. Mechanical agents are the cause of abrasions and lacerations of the skin. Of course, chemical substances are the common primary irritants.

Primary irritants cause various degrees of inflammation and at times they cause destruction of the cutaneous and subcutaneous tissues. Fortunately, the worker shows consideration for the primary irritants and tends to avoid them in his work. The cutaneous damages caused by these irritants tend to repair themselves in most instances if they are treated conservatively.

#### INDUSTRIAL DERMATITIS DUE TO SENSITIZERS

This particular type of inflammation is known by various names, but the sophisticated public gives it the name of allergic dermatitis. Regardless of this and the many external causes, it is inflammation of the skin caused by repeated contact of cutaneous irritants that ordinarily are harmless. In industry, sensitization accounts for 20 percent of the cases of industrial dermatitis. The worker is unable to understand why the first contact with a sensitizer failed to produce a visible change on his skin, and then subsequent attacks, exposure of small amounts, or quantities, cause a localized inflammation or even a generalized, disabling attack.

In industry, the sensitization is acquired. The onset is gradual, as a rule, or it may be sudden under certain conditions. The area first affected is the one of maximum exposure to the sensitizer, usually the hands, and later the forearms, face, and neck. If the incubation period of the disease is short in a new worker, the cause is determined without too much difficulty. In some cases the responsible sensitizer may be proved by means of a patch test. The prognosis of industrial der-

matitis due to sensitizers should be guarded.

#### SPECIAL FEATURES

The medical criteria in the diagnosis of industrial dermatitis due to sensitizers are: (1) the disease appears during, or within a few weeks after, the time the worker begins handling sensitizers. A delayed onset does not rule out the sensitization factor in some cases; (2) amelioration of the eruption after cessation of work — a period of weeks or months. Sensitization to other substances may prolong the course of the disease. Added bacterial infection or the retention of causal substances may prolong or change the course of the disease; (3) recurrence of dermatitis if the worker is returned to identical sensitizers in his industrial work; (4) sensitization dermatitis begins in the areas of maximum exposure, and this is usually the hands; (5) fellow employees show similar cutaneous disease, or the disease is known from previous experience to be caused by exposure to the sensitizer.

One-third of the cases of so-called industrial dermatitis, upon examination, are found to be common diseases of the skin; for example, psoriasis, seborrheic dermatitis, lichen planus, dermatitis (non-industrial), etc. Occasionally industrial dermatitis is superimposed on a non-industrial dermatosis.

#### PREVENTION

The prevention of industrial dermatitis depends upon: (1) clean industrial environment; (2) avoidance of cutaneous irritants; (3) protection of the skin by wearing gloves, aprons, sleeves, and masks; (4) protective ointments; (5) sufficient time for cleaning the skin; (6) avoidance of solvents for cleaning the skin; (7) mild soaps instead of strong ones.

# What Every Doctor Should Know About Solvents

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Polly Adler has written that a "House is not a Home," revealing that in certain houses there is carried on a thriving, albeit, illegitimate business. We can expand Miss Adler's limited meaning by claiming every home is an industry — a small plant utilizing degreasing solvents, detergents, insecticides, pesticides, bleaches, petroleum distillates and all types of machinery and powered gadgets. Therefore practically all doctors, their wives, their children and household help are exposed with fair frequency to materials which *may* be toxic or harmful. To carry this contention further it can be stated that leaving the home and going into industry practically all patients of practically all physicians are daily exposed to toxic solvents or their gases. It would seem imperative, then, that the medical profession gain some knowledge regarding these so-called industrial solvents.

A solvent is a liquid capable of vaporizing under certain conditions. Varying degrees of intoxication may occur by means of absorption of a few of these solutions through the skin but invariably intoxication is the result of *inhalation* of the vapors. Since these commercial solvents are legion each one cannot be considered individually. It is therefore the writer's aim to present a useful classification with a discussion of a few of those frequently utilized in industry or in the home.

## CHEMICAL CLASSIFICATION

A complete chemical classification would require a differentiation between saturated and unsaturated compounds and distinguishing between the aliphatic and aromatic series. It would have to include the various subdivisions in order to arrange properly the alcohols, the aldehydes, the esters, the ketones and so on. But for the purpose of simplicity it can be stated that the largest chemical group are the aliphatic hydrocarbons. A table at the end of this paper lists the more common ones. The aromatic hydrocarbons compose a smaller group likewise noted in this table. Certain additions could be made to these two but

such will suffice for the purpose of this paper.

## PHYSIOLOGICAL CLASSIFICATION

In regard to their physiological reaction, the solvents or their gases are divided into four groups, namely, the irritants, the asphyxiants, the narcotics or anesthetic and the inorganic or organometallic gases. This last group arises from lead, mercury, cadmium, etc. These are outside the realm of this discussion.

In attempting to assay the harm done by an undue exposure to a solvent it is most important that one adhere to this physiological classification. For instance we do not expect an irritant to have narcotic properties. Likewise only under the most unusual circumstances would an anesthetic gas irritate the mucous membrane. Let us now consider the physiological groups.

1. *The Irritants*:—While it is true that the various irritants differ widely in their chemical and physical properties they have, nevertheless, one common physiological reaction which is, an inflammatory reaction upon the tissues in which they come in direct contact. The tissues involved are primarily the eyes, the membranes of the respiratory tract, and in some instances the skin. When these irritant gases affect the aforementioned parts of the body there is usually a disturbance to the vital processes as for instance coagulation, liquefaction, dehydration or such similar injury. This type of disturbance is essentially the same for all irritant gases and vapors.

Although the reaction to all irritant gases is essentially the same as far as the effect upon the tissues is concerned, the symptomology may vary to a great extent. Certain irritant gases act upon the nose and throat or the eyes producing what could be called rhinitis, pharyngitis or a laryngitis or a conjunctivitis. Other irritant gases fail to affect the upper respiratory tract and may act upon the bronchi or the lung tissue producing a bronchitis, a chemical pneumonitis, or pulmonary edema. To illustrate the difference, exposure

to ammonia gas in fairly high concentrations produces intense congestion and swelling of the upper respiratory passages. It particularly affects the eyes, nose and larynx. It rarely affects the lungs proper. In contrast phosgene or nitrogen peroxide will cause little or no reaction to the upper respiratory passages but will induce pneumonia or pulmonary edema. Chlorine gas is an example of intermediate gas in which the usual affect is upon the eyes, nose and throat but if the concentration is sufficiently severe and the exposed individual cannot escape from the gas the lungs may be affected.

Any gaseous irritant which is highly soluble in water is absorbed from the inspired air by contact with the first moist tissue which it reaches in the respiratory passages. As a consequence, the upper respiratory tract bears the brunt of the action; the lungs are relatively little affected, since the concentration of the irritant which reaches them is greatly reduced by absorption in the upper passages. With those gases which have a low solubility, the upper respiratory passages suffer little, for little is absorbed, and the main damage is deep in the lungs. A gas of moderate solubility exerts its action more or less uniformly throughout the entire respiratory tract. Thus, as a general rule, the irritant gases are dangerous inversely as their solubility; the less soluble any one of them is the more insidious is its action.

In addition to the point just made regarding solubility, I would like to also point out that the severity of the action of the irritant gases is not to be estimated on a basis of concentration of the gas multiplied by the duration of the exposure to it. In other words, an irritant gas does not have the same dependency upon duration plus concentration as does an asphyxiant gas such as carbon monoxide. A high concentration of ammonia or chlorine, even for a short time, may have a serious affect. However, a reduction of one half the concentration would permit the exposed individual to remain in the atmosphere twice as long, therefore, concentration is an important factor in estimating the degree of the injury apt to occur from an irritant gas.

There is still one more important point which I would like to emphasize at this time, namely, the protective reflex which goes into action whenever one is exposed to an irritant gas. This

protective reflex consists of coughing, constriction of the larynx and bronchi, closure of the glottis and the inhibition of respiration. Practically all of the primary irritants will produce immediate coughing upon exposure. The type of coughing which ensues is usually a series of expiratory blasts which tend to expell the irritant material. An additional value to the coughing mechanism is that it warns the individual of the presence of an irritant gas and he naturally removes himself from his exposure. Likewise, in addition to the cough mechanism and the closure of the glottis, the irritant acts upon the larynx and at the same time upon the superior laryngeal nerve. This stimulation to the nerve produces an inhibition of respiration with the chest held in a position of expiration. Obviously this inhibition of respiration is only temporary and ceases when the lack of ventilation produces excitement to the respiratory center and inspiration is again invoked.

The primary irritant gases are ammonia, hydrochloric acid, sulphuric acid, hydrofluoric acid, formaldehyde, sulphur dioxide, chlorine, bromine, iodine, phosphorous and one or two others.

Chlorine is one of the most extensively used gases in industry. Because chlorine is an extremely irritating gas, an exposed individual usually withdraws before severe gassing takes place and therefore the lungs usually escape any severe injury. On the other hand, if one is forced to stay within a concentration that is sufficiently high for any length of time the lungs will be affected. This is likewise true of those instances where a blast of chlorine will strike an individual. Coughing will result almost immediately. In severe gassing the feeling of suffocation will be experienced in addition to the aforementioned signs of irritation. If the lungs are involved, as evidenced by rales, pneumonitis or pulmonary edema may ensue. Pneumonia is a rare sequel, and to be attributable to the affects of chlorine, it should have its onset within a few hours to a few days following exposure. It is believed that exposure to chlorine does not induce the appearance of pulmonary tuberculosis.

The temporary disability is short, lasting from a few hours to a few days, in mild to moderately severe cases. The writer has never seen a case of permanent disability due to chlorine gassing.

Sulfur dioxide is an irritating gas arising

from the combustion of sulfur. It is a common component of the atmosphere of industrial communities and can easily be detected in the air. Its concentration is higher in cities subjected to fog.

Its most frequent use is in the operation of small, home refrigeration units. Exposure may also be found in the occupations of sulfuric acid makers, smelters, foundry workers, blast furnace operators, bleachers, cellulose workers, workers at coke ovens, disinfectant workers, dyemakers, petroleum refiners and vulcanizers.

Irritation and inflammation to the eyes, nose, throat and lungs and occasionally digestive disturbances. It is so irritating to the eyes and throat that man usually withdraws from an exposed atmosphere before further damage is done; but instances where withdrawal was impossible are reported, showing edema of the lungs, as well as, paralysis of the respiratory center.

Nitrogen dioxide is a gas remarkable for its change of color with the change of temperature. When cooled it is a pale yellow and at room temperature it is a reddish brown, but when heated it becomes deep, chocolate brown.

In whatever molecular form the dioxide is inhaled, it is at once altered into that form corresponding to body temperature. At 40 degrees C. approximately 30 percent of the dioxide is in the form of  $\text{NO}_2$  and 70 percent,  $\text{N}_2\text{O}_4$ . It is in this proportion that the gas acts upon the respiratory tract, where it decomposes into nitric acid and nitrous oxide. In reacting with the alkalis in the respiratory tract, a conversion into nitrates and nitrites is brought about. It is the nitrite which, when absorbed, causes a marked systemic reaction.

The possibilities of the presence of undue amounts of nitrogen dioxide are many if precautionary measures are inadequate. An exposure exists in the manufacture of explosives or in the making of nitrocellulose, in photoengraving and in making photographic films, in metal etching, in pickling, in welding and oxyacetylene operations, as well as in carbon arc booths.

If the dosage is overwhelming and death occurs immediately, there will probably be no pathologic changes noted at postmortem other than congestion of the lungs. In those cases where death was delayed or in the severely intoxicated there is a change of the arterial blood

to venous, the presence of hemorrhages into the various organs, edema of the brain, tracheobronchitis, broncho-pneumonia and pulmonary edema. Pulmonary edema is the most frequent finding.

It should be emphasized that the symptoms are usually delayed. This latent period may be from a few hours to twenty-four or thirty hours. Unquestionably this offers difficulty in some instances in diagnosis, and unless the facts are known the etiology may be overlooked.

I think that this might be an opportune time to mention the sequelae of exposure to the irritant gases. The report of the Surgeon General of the U.S. Army for 1919 showed that among 70,552 American soldiers who had been gassed, 173 cases of tuberculosis subsequently developed, a rate of 2.45 per 1,000. The corresponding rate for all enlisted personnel overseas was 3.50 for 1918 and 4.30 for 1919. In 1930 Price summarized the experience for the armies of all the warring nations and reported the general feeling that war gases had no influence upon susceptibility to tuberculosis.

This mature conclusion reversed that reached after the first year's experience, when most authorities were convinced that the acute inflammatory reactions must have been responsible for the increase in number of tuberculosis cases in the armed forces. Koontz made numerous experiments on the effect of gassing tuberculosis rabbits for the Chemical Warfare Service and reported no alteration in native susceptibility to this infection.

2. *Asphyxiants*: The two asphyxiants of industry are carbon monoxide and cyanide. The signs, symptoms and pathology of carbon monoxide are so well known to all physicians that these will be omitted from this discussion.

3. *Anesthetics or Narcotics*: This is the most important group to be discussed. Likewise, it is the most interesting group. It is within this division that the greatest advancement in industrial chemistry has been made.

The physiological action common to all of these anesthetic gases and vapors is that they exert their major action *after* being absorbed into the blood. This action is primarily upon the central nervous system and certain of these volatile gases have virtually no other action on the body. There are a few which, in addition to their anesthetic or narcotic action affect certain organs

of the body such as the liver and kidneys. The anesthetic action varies in its intensity, there being certain of these gases which have a mild anesthetic effect while others have a strong and intense affect.

Ordinarily the anesthetic gases do not produce any chronic poisoning. When one considers the reaction to chloroform or ether and appreciates that following the removal of the anesthetic the nervous system returns to its original state of health. Following any single exposure to an anesthetic gas there occurs the normal exchange of oxygen and the removal of the gas from the system. Therefore, in the group known as the primary anesthetics we do not expect to see any chronic poisoning or permanent damage from these individual episodes of exposure. In some of the *subdivisions* of the anesthetic group, however, there are certain chemicals which have the ability to cause permanent damage or prolonged disability due to chronic exposure. Methyl alcohol is an example of this as is also benzol or carbon disulfide.

*Methyl alcohol* is used as a solvent in preparation of varnishes and lacquers, in the manufacture of some synthetics, in resins and stains. This alcohol damages chiefly the nervous system particularly the optic nerve and may result in blurred vision, pain in the eyes, and partial or even permanent blindness. The toxic properties of methyl alcohol have been ascribed mainly to its oxidation products formaldehyde and formic acid. Methyl alcohol is eliminated very slowly from the body. Thus, accumulation can take place and repeated small exposures can be harmful whereas a single exposure would cause no damage. Obviously this observation applies to the inhalation route.

*Ethyl alcohol* is used in industry as a solvent and is the chemical starting point for many compounds. It is rapidly excreted by the body and does not cause serious poisoning in industry.

The higher alcohols such as propyl, butyl and amyl are more toxic than ethyl but because of lower vapor pressure and lower solubility they cause very little trouble in industry. Butyl alcohol fumes sometimes cause irritation of the eyes and dermatitis of the hands.

*Aldehydes*: The commonest aldehydes are formaldehyde and acetaldehyde and are derived

from oxidation of primary alcohols. These compounds are not solvents, but since they are so closely related, chemically, we will mention one typical example.

Formaldehyde is used for disinfecting purposes, in tanning and brewing; it is used in glass etching and in the production of plastics such as bakelite. As a gas, formaldehyde is a marked irritant to the mucous membranes of the respiratory tract. Because of this irritant property, people stay away from it and it does not produce chronic poisoning. Solutions of formaldehyde are irritating to the skin and frequently cause dermatitis in industry.

*Ketones*: The ketones result from oxidation of secondary alcohols and the simplest member of this family is acetone. Acetone is widely used as a solvent in industry but has no serious effects when the fumes are breathed. Butanone is another ketone used in industry. This material is a mild irritant to the central nervous system in some people.

**HALOGENATED HYDROCARBONS**: The halogenated hydrocarbons are hydrocarbon molecules containing one of the halogen group — fluorine, chlorine, bromine or iodine.

*Methyl bromide* is used in the dye industry, as a fumigant and as a fire extinguisher. It has widespread usage in the date and fruit packing industry. Chronic poisoning produces a bizarre clinical picture characterized mainly by visual disturbances, mental confusion and speech disturbances. The pathological action is due to the methyl bromide molecule itself and not to any degradation product. This molecule produces changes in the lower sections of the brain — the basal ganglia, the cerebellum and the pyramidal tract. These pathological changes have not been permanent in the writer's experience.

*Methyl chloride* is used as a refrigerant, is used in the dye industry, in perfume manufacturing and in the pharmaceutical industry. Chronic intoxication, such as may be found among refrigerator plant workers or repair men is characterized by restlessness, insomnia, staggering gait, visual disturbances and tremors. There are no permanent sequelae if the patient is removed from exposure.

*Chlorinated hydrocarbons*: The chief members of this group are carbon tetrachloride, tri-

chloroethylene, tetrachlorethane, and tetrachloroethylene and the chlorinated naphthalenes. In a strict chemical category these chlorinated hydrocarbons belong to the halogenated hydrocarbon group but they are so commonly spoken of as the chlorinated hydrocarbons.

*Carbon Tetrachloride* acts primarily upon the central nervous system as an anesthetic. A secondary effect is upon the liver and kidneys. This solvent is less narcotic than chloroform but is much more toxic. Acute exposure to mild concentrations will result in headaches, drowsiness and a feeling of tiredness. If the concentration is sufficiently severe to cause extreme degrees of narcosis or coma, the exposed individual may recover completely as he would from any anesthesia or he may have a delayed secondary affect upon the kidney and liver. The delay in such instances is usually from a few days to two weeks and primarily the involvement is that of the kidneys. Occasionally the liver is also involved, but not as frequently as the kidneys. Mild intoxication will not produce kidney or liver damage. This hepato-renal complication occurs most frequently in the heavy alcoholic drinker. The anesthetic gases have no affect upon the heart other than to cause a ventricular fibrillation or cardiac arrest.

Carbon tetrachloride is an excellent solvent for greases and fats and has a widespread use in industry as well as in the home. Many products are put out with trade names which contain carbon tetrachloride and these solvents or degreasing agents are used rather recklessly within the home.

In the treatment of carbon tetrachloride a regime should be instituted to support the deficient kidney and liver function. This should include amino acids and diet high in protein and carbohydrates except meat proteins. Since meat proteins produce guanidine, this substance is apt to prolong the symptoms of carbon tetrachloride poisoning. If the patient appears to be in cardiac collapse epinephrine should *not* be given.

*Trichlorethylene*. This solvent is finding greater use in industry because it is much less toxic than carbon tetrachloride and in many instances will do the work as well if not better than carbon tetrachloride. Therefore, it is taking the place or being used as a substitute for carbon tetrachloride.

The primary action of trichlorethylene is upon the central nervous system. Mild exposure to trichlorethylene causes lassitude and sleepiness, and a more intense exposure may cause symptoms of drunkenness. Some individuals find the mild toxic effect from these two solvents to be pleasant and they become addicts and are often caught taking whiffs from a cloth or from an open vessel. Exposure to trichlorethylene even when severe leaves no sequelae. The patient usually recovers within a few hours to several days. It does not cause liver or kidney damage.

*Tetrachlorethylene* or as it is sometimes known, perchlorethylene is much safer to use than carbon tetrachloride or trichlorethylene and is a degreasing agent of choice.

**AROMATIC HYDROCARBONS:** Leaving the aliphatic hydrocarbons we come to the aromatic hydrocarbons. The commonest member of this group is benzol or benzene. It is important that we distinguish benzene from benzine since the benzine is a petroleum distillate and is not nearly as noxious as benzene which is a coal tar product. For the sake of distinction the word benzol should always be used, when we speak of the coal tar product.

Acute benzene poisoning is very rare and in overwhelming doses could act as both a narcotic and an irritant.

Chronic benzol poisoning produces an anemia which is atypical. The blood picture is bizarre and inconstant. The more constant findings are those of an increase in the mean corpuscular volume, that is, the average cell-volume is over 94 cubic microns. The symptoms are those of weakness, nervousness, loss of weight and a general picture that one sees in anemia. In advanced cases there may be hemorrhages because of the thrombo-cytopenia. Since the picture of benzol anemia often simulates pernicious anemia, the finding of free hydrochloric acid in the stomach content in benzol poisoning will differentiate it from pernicious anemia. Likewise, a urine sulfate test is of value. In the worker exposed to benzol the inhalation of this material causes the percentage of urinary organic sulfate to rise and the inorganic urinary sulfate to fall.

*Toluol* is often used as a substitute for benzol because it is much less toxic. However, one has to be certain that toluol is pure and does not

contain some benzol as so often happens in industry. There is a considerable difference of opinion among toxicologists as to the affect of toluene and xylene after prolonged exposure. Certain investigators, particularly the German investigators, feel that both toluene and xylene can produce some degree of anemia.

*Aniline* is an aromatic compound which is used in industry as a starting point for the production of many chemicals. It is absorbed either by inhalation or thru the skin. Aniline intoxication may produce loss of appetite, headaches, vertigo and some other nervous disturbances. For many years it was believed that the tumors which occurred in the dye industry, that is the manufacturing of the dyes, resulted from the exposure to beta-naphthylamine and benzidine rather than to aniline. The most recent investigations exonerate aniline entirely as the cause of bladder tumor.

**THE INSECTICIDES:** The oldest insecticides such as rotenone, pyrethrum, piperine and nicotine were obtained from botanicals. Unless ingested these are relatively harmless. These substances are capable of causing irritation to the skin and mucous membranes.

During World War II the chlorinated hydrocarbon insecticides were introduced. The first of these to gain attention was DDT. Since it is insoluble in water it is usually dispensed in a petroleum solvent or as a wettable powder. Because it can accumulate in the fatty tissues of animals its use is discountenanced in dairies. Likewise food should not become contaminated by it. Ordinary exposure causes no harm as evidenced by the absence of injury among thousands who manufacture the product or troops who were sprayed with it. Undue contact can produce a dermatitis and ingestion causes nausea, vomiting, abdominal pain, stiffness of the joints and nervousness.

Other chlorinated (halogenated) insecticides are best listed under their trade names. These are lindane, chlordane, aldrin, dieldrin, toxaphene and related chemical compounds. Initially it was believed that these substances if absorbed, would affect the liver, kidneys and possibly the nervous system. These conclusions were reached upon the bases of animal experimentation. But further studies led to the conclusion that animal experimentation did not give reliable evidence of human toxicity. A series of studies on the effect

from this group of insecticides among workers in the manufacture and formulation of these substances revealed no evidence of poisoning under ordinary care.

Assuming that undue exposure has occurred then one could expect nervous system stimulation, kidney and liver damage. The treatment is supportive and non-specific.

The third and most notorious group of insecticides is that represented by the organic phosphates. They were evolved for use in chemical warfare and are popularly known as the "nerve gases." Again the long chemical names will be omitted and the more common ones will be referred to as bladon, vapatone, parathion, malathion and schradan. Although there is some variance, the pharmacological reaction among this group is similar. For the purpose of this paper parathion poisoning will be described.

Parathion is a potent anticholinesterase agent (cholinesterase is a plasma and red blood cell enzyme). Intoxication can occur following inhalation, absorption through the skin or by ingestion. Skin irritation is frequent. Reaction to exposure may be immediate, within a few hours or be cumulative. Instances of poisoning have been reported in orchard pickers who have gone into the orchard 10 days after it had been sprayed with parathion.

The initial symptoms are headache, dizziness, vomiting, weakness, pains in the chest and abdomen. The physical findings are pin-point pupils, pallor, excessive sweating, deficient vision, labored respirations, and muscular twitching. Conformatory laboratory aides are (1) the determination of the cholinesterase values of the red blood cells and (2) the presence of paranitrophenol in the urine.

The treatment of parathion poisoning is primarily heroic doses of atropine, i.e. 1 to 2 milligrams of atropine as necessary until the muscarinic effects of parathion have been overcome. Oxygen may be necessary. The skin should be thoroughly washed and all contaminated clothing decontaminated by a strong alkaline solution.

#### SUMMARY

The use of the so-called industrial solvents is no longer confined to a plant or factory. In various forms they are utilized in the home, in the garden and on the farm. Rarely are they harmful

if handled judiciously. A physician should be able to advise his patient what the preventive measures (careful handling) are. He should likewise recognize the ear marks of any given intoxication if and when it occurs. His treatment

should be based upon his knowledge of the expected physiological and pathological reaction. The physiological classification of these solvents is therefore very important.  
520 W. 7th St.

# THE SOLVENTS ALIPHATIC or PETROLEUM SERIES R. T. Johnstone, M.D.

## Toxic Effects

1. The Alcohols:  
Methyl, ethyl, propyl, butyl, amyl  
C. N. S. Mild to severe. Optic neuritis or atrophy. Higher alcohols per se **not dangerous**.
2. Acetates:  
Methyl, ethyl, amyl, butyl  
(Methyl ethylene glycol acetate)  
(Ethyl ethylene glycol acetate)  
Rarely cause any trouble. Could be respiratory irritants or mild CNS irritant
3. Acetones: Ketones:  
Acetone (dimethylketone)  
Methylethyl ketone (butanone)  
Methylpropyl ketone (pentanone)  
Questionable but possible CNS depressant.
4. Aldehydes:  
Formaldehyde, paraldehyde, acrolein  
Irritant to eyes, throat, nasal passages, skin  
Higher concentrations—headache, dizziness, tightness of chest.
5. Glycols:  
Ethylene glycol monoethyl ether (cellosolve)  
Ethylene glycol monoethyl (methyl cello-solve)  
Controversial observations.  
Anemia, irritant to CNS.
6. Aliphatic Oxides:  
Oxidation of aliphatic acids yield carbon monoxide and carbon dioxide  
Phosgene—formed from carbon monoxide and chlorine.  
Asphyxiant  
Mild—headache, drowsiness.  
Moderate—coma.  
Severe—coma, death.
7. Aliphatic Nitrates:  
HCN  
Asphyxiant  
Coma—death
8. The Chlorinated Hydrocarbons:  
A. Saturated Compounds  

Common Name	Chemical Name
Methyl chloride	Monochloromethane
Carbon tetrachloride	Tetrachloromethane
Ethylene dichloride	Dichlorethane
Ethylene trichloride	Trichlorethane
Acetylene tetrachloride	Tetrachlorethane

  
B. Unsaturated Compounds  

Acetylene dichloride	Dichlorethylene
Acetylene trichloride	Trichlorethylene
Tetrachlorethylene	Tetrachlorethylene
Halowax	Chlorinated naphthalenes

  
Most of these have CNS effects of varying degrees from acute exposure. Some affect kidneys, liver (carbon tetrachloride). Few affect the skin (trichlorethylene, chlorinated naphthalenes) or eyes. Controversial blood effects.
9. Aliphatic Sulfur Compound:  
Carbon Disulfide  
Marked, varied, and bizarre CNS lesions.
10. Bromine and Chlorine Compounds of the hydrocarbons:  
Methyl bromide, ethyl bromide  
Methylchloride, ethyl chloride  
Irritation to respiratory tract. Mild to severe CNS disturbance—invariably not permanent.
11. Mixed Hydrocarbon  
Gasoline (Benzene)  
Rarely source of trouble.  
Headache, dizziness (naphtha jag).
12. Pesticides  
See context of article.

## AROMATIC or BENZENE SERIES

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|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| <p>1. Aromatic Hydrocarbons:<br/>Benzol (benzene, toluene, zylene)</p> <p style="padding-left: 40px;">Phenol</p>                                                                                                           | <p>Acute exposure—CNS depressant—narcotic. Chronic exposure—marked and varied effect on blood and blood-forming organs.</p> <p>Skin irritant and corrosive. Marked absorption toxic to CNS.<br/>Kidneys.</p>                                                                          |
| <p>2. Aromatic Amines: .</p>                                                                                                                                                                                               | <p>CNS irritant, kidneys.<br/>Bladder tumors?</p>                                                                                                                                                                                                                                     |
| <p>3. Aromatic Nitro Compounds:<br/>Nitrobenzene<br/>Nitrotoluene<br/>Trinitro toluene<br/>Tetryl</p>                                                                                                                      | <p>CNS depressant. Cyanosis.<br/>Anemia.<br/>TNT is a skin irritant.<br/>Blood changes (controversial picture).</p>                                                                                                                                                                   |
| <p>4. Naphthalene Derivatives:<br/>Naphthalene</p>                                                                                                                                                                         | <p>Mild narcotic action.<br/>Prolonged exposure affects the eyes.</p>                                                                                                                                                                                                                 |
| <p>5. Halogens and Halogen Compounds<br/>Bromine, chlorine, iodine<br/>Hydrogen fluoride</p> <p style="padding-left: 40px;">Hydrogen sulfide</p> <p style="padding-left: 40px;">Nitro derivatives<br/>Nitrogen dioxide</p> | <p>Eyes and respiratory tract.<br/>Irritant, gastro-intestinal disturbance, disturbance of calcium metabolism.</p> <p>Cell and nerve poisoning. Paralysis of respiratory center.</p> <p>Respiratory irritant, pulmonary edema.<br/>Methemaglobinemia. Immediate or delayed death.</p> |

## HEAT THERAPY

The physiological response to heat is vasodilatation, increased rate and volume of blood flow, and increased metabolism of the tissue. In general, conductive heat (hot packs, whirlpool bath, paraffin) penetrates only the superficial layers of the skin; luminous radiation (baker) penetrates the skin and to a lesser extent causes elevation of the temperature of the tissues lying a short distance beneath it; conversive heat (diathermy) is the most penetrating form available for therapeutic use. In selection of the proper agent for thermal effects, several factors should be taken into considera-

tion: the depth of penetration desired, the location and extent of the area to be heated, and the ease and efficiency of application as determined by available modalities. It usually is more satisfactory to order treatment that can be repeated at home, and for this reason the more simple methods of heating are indicated. The indications for the application of heat are numerous and well known. Briefly, heat is used for increase of local circulation, for relief of pain, for relief of muscular spasm, and to increase phagocytosis in inflammatory areas. *Louis P. Britt, M. D., Physical Therapy In Office Practice. J. Tennessee M. A. June 1954.*

# A Program of Prenatal Pediatric and Obstetric Instruction

**James B. Gillespie, M.D. and Thomas R. Wilson, M.D.**  
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Providing prenatal instruction and advice on care of the newborn is the responsibility of the obstetrician and pediatrician. The obstetrician frequently does not have the time to provide adequate information to each patient in the office, and the pediatrician usually has no contact with the mother prior to her delivery. The prepartum patient in these circumstances often is uninformed or poorly prepared concerning normal and abnormal maternal changes of pregnancy, obstetrical anesthesia, delivery, and care of the newborn infant. Insecurity and apprehension may result and the prepartum and postpartum periods become anxious ones for the mother and trying for the physician.

The obstetrical patient demonstrates interest and even concern with the anatomic and physiologic changes of pregnancy and asks many questions about labor, obstetrical anesthesia, and maternity care in the hospital. Many months before the baby is to arrive, she displays an avid interest in all matters pertaining to infant care. With limited time for office instruction, it is desirable to provide a program, outside the physician's office, to give appropriate information on infant and maternal care to a group of maternity patients. This type of instruction permits each woman to become acquainted with the pediatrician several months before his services are required. Moreover, by group instruction, the obstetrician is permitted to discuss more thoroughly many matters of common interest to all expectant mothers. The pediatric and obstetrical implications are so closely tied together during this prenatal period that a program which consolidates maternal and newborn care is ideal for physicians and patients. The emotional attitude of the expectant mother is improved by recurrent contacts with her obstetrician and an opportunity to meet the physician who will care for her baby.

Informal group discussions and conferences may be conducted in an atmosphere devoid of the rush and tensions associated with office visits. Each patient derives a certain security from a prenatal program in which she is one of a group of expectant mothers. Questions which would not have been asked in the physician's office, are frequently raised in conference. Increased confidence and cooperation and improved patient-physician relationships are stimulated in conferences. Also, the office time of the physician saved is many times greater than that expended in group instruction.

Clinic type practice provides a situation which facilitates the development and presentation of a program of prenatal pediatric and obstetric instruction. A program designed for instructing patients of the Department of Obstetrics of Carle Hospital Clinic on maternal and newborn care was initiated early in 1946. The purpose of this report is to describe the program and to comment on the merits of group instruction based upon observations by staff members of the Department of Pediatrics and Obstetrics.

The program is described by the obstetrician at the first visit of the patient; she is informed of the series of conferences to be held at the beginning of her last trimester. Since the nutritional aspects of maternity care are necessarily individualized, this information is chiefly provided at the monthly prenatal visits to the obstetrician. Just prior to the scheduled conferences, usually during the preceding week, a mailed invitation is issued to each patient advising her of the place of meeting, date, and hour. These informal meetings are held at weekly intervals in a comfortable conference room during the early evening. Husbands are invited to attend if they desire. A registered nurse, responsible for the general administration of the program, is in attendance at each session. She acts as a liaison between physicians and patients

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throughout the entire program. Part of her time is spent in the prenatal clinic so that she is personally acquainted with every patient to be delivered.

The initial conference is conducted by the obstetrician and in a one to one and one-half hour period a general outline of prenatal care is presented. The discussion includes a brief resume of the physiology of pregnancy, the anatomic changes in the prepartum period, growth of the fetus, and description of the common symptoms experienced during pregnancy. Clothing, exercise, diet, and the symptoms and signs of onset of labor are described. Emphasis is placed upon the time to go to the hospital. The stages of labor, the methods of sedation used in the conduct of labor, and the various types of anesthesia together with their advantages and disadvantages are described in moderate detail. A popular portion of the presentation has been an illustrative, hypothetical case describing events from the time the patient notes beginning labor. This patient's course is detailed from the time of her arrival at the hospital; hospital registration, preparation for delivery, and the general conduct of labor. Subsequent to the obstetrician's presentation, considerable time is allotted for questions and general discussion. Pediatric questions are frequent in obstetrical practice, but they are all deferred until the two pediatric conferences which follow in the next weeks.

The conference hour in the following week is devoted to infant feeding and is conducted by a member of the pediatric staff. The advantages of breast feeding for the mature newborn are stressed early in the meeting and all patients are urged to consider it the method of choice. Evaporated milk, pasteurized whole milk, proprietary foods, and the several carbohydrates used in infant feeding are discussed. The technics of formula preparation and equipment are described. A variety of suitable equipment such as bottles, nipples, caps, sterilizers, brushes, measuring cups, and other accessories are available for inspection and demonstration. Proper technics and schedules for breast and bottle feeding are described and improper methods are mentioned. The indications for complementary feeding and weaning are given briefly. Colic is discussed and suggestions for the relief of simple constipation and gaseous distention are made. Following

the informal presentation, the topic of feeding is opened to questions and discussion. Frequently multiparae in attendance express their own opinions relative to matters of milks, bottles and feeding technics. Questions pertaining to self-regulatory schedules invariably are raised by one or more mothers.

The third and last conference is devoted to a miscellaneous group of topics of pediatric interest. Bathing, including technic of the bath and use of soaps, oils, creams, and powders are discussed extensively. Clothing and layette requirements are discussed as well as the laundering of infant's garments. Sleeping habits, bowel habits, fresh air, sunbaths, and the development of the various senses as sight, hearing, smell, taste, and touch are reviewed. The variations in crying and its causes receive attention. Several of the mild but common abnormalities in the newborn such as infantile mastitis, nevi, umbilical hernia, and infantile strabismus are considered. The mothers are reassured as to the prognosis of these minor variations from the normal. Bassinettes, cribs, beds, and sleeping garments are described and suggestions are made as to the most suitable equipment. There are available for demonstration infant clothing needed for the newborn as well as other accessories.

Patients are advised of the worthwhileness of periodic checkups for the baby and as to the importance of keeping developmental and immunization records. At the close of the lecture several minutes are devoted to general orientation, the importance of handling the infant as an individual, and matters of training. Published booklets, books, and pamphlets on infant care and several books for infant's records are on hand for inspection. Each patient is urged at this final conference to ask any question which has been unanswered in previous meetings.

All conferences are conducted as informally as possible and in a manner reassuring and easy for the patients. The normality of most pregnancies and the simplicity of infant care are stressed. A stereotyped presentation has been avoided and the discussions vary, depending upon the questions and special interests of a particular group. Approximately 24 to 25 mothers attend each conference. The patients include both primipara and multiparae, many mothers returning to at-

tend conferences during a second or third pregnancy. Conferences are held regularly throughout the year except in July and August.

Each mother is encouraged to have her husband accompany her to the hospital when labor begins. There is less apprehension and more cooperation when he is present to give moral support during the labor. If the husband is not available, the presence of another member of the family is encouraged. Delivery rooms are so arranged that the husband may observe the delivery procedure through a glass panel, when desired. This physical arrangement allows the husband to observe without being actually present in the delivery room and the opportunity ordinarily is enthusiastically received by both husband and wife.

To complement the prenatal instruction program, each postpartum patient in the maternity department is seen daily by the pediatrician. She is informed of the daily progress of her baby, problems arising during the hospitalization are discussed, and some matters of infant care may be more individualized in this period. Just prior to dismissal from the hospital the pediatrician outlines feeding and other pertinent information. The mothers are urged to ask questions and explicit answers are attempted. The registered nurse assigned to administration of the program visits each mother daily and demonstrates the technic of bathing the infant to each patient. Three to five days subsequent to discharge of mother and infant, the nurse makes a visit to the patient's home, where any difficulties are noted and general advice for correction or solution of a nursing or other problem may be given. The nurse records information for the obstetrician and pediatrician on special forms after superficial examination of both patients, and this information is returned to the respective physicians. In a problem of magnitude the physician promptly contacts the patient so that the situation may be corrected. Visits by the nurse are limited to patients in Champaign-Urbana for it has been found impractical to attempt such services outside the corporate limits. During the first five years of the program 1,566 home calls were made to obstetrical patients by the visiting

nurse. This service has been welcomed by the mothers in every instance, it has been informative to both obstetrician and pediatrician, and has permitted an improved followup of each patient.

Approximately two-thirds of all obstetrical patients participate fully in the program of prenatal and postnatal instruction. The nonparticipating patients, chiefly from rural areas or other cities, have a problem of transportation to the evening conferences. However, it has not been uncommon for some patients to drive 50 miles to be regular attendants at the group meetings. The total attendance at the prenatal conferences in the years 1947-1951 inclusive was 3,768.

The interest of obstetric patients in maternal and infant care by group instruction has been keen. The comment frequently is made that more useful information has been provided by this means than could possibly have been divulged in the obstetrician's office. The patients have been delighted to meet the pediatrician several months prior to delivery and to hear an outline of infant care from the physician who will care for the baby. Group discussion lacks formality and fosters comfortable physician-patient relationships which are reassuring to expectant mothers. The importance of improved psychological and mental health implications in the care of the obstetric patients is obvious.

Lack of information and improper information may be the source of considerable concern to this group of patients. Unhappy situations have been less frequent with an integrated program of instruction on maternal and infant care. The association in conferences with other mothers, similarly uninformed, provides each patient with a feeling of comradeship during the process of learning.

The physician has found that the demands by patients in the form of protracted office discussions and numerous telephone calls have been lessened both before and after delivery. Improvement in patient cooperation subsequent to institution of the program has been noted. The advantages of this type of program have been sufficient to justify continued operation of such a plan for all obstetric patients.

# Parturition Following Operations on the Cervix

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In spite of the fact that the number of major formidable operations on the cervix has been decreasing during the past few years, physicians are still confronted with obstetrical care for those patients, who have had operative procedures performed on the cervix. This report deals primarily with parturition following Duhrssen's incisions of the cervix and Stuhmrdorf trachelorrhaphy. With regard to the effect of conization of the cervix on subsequent pregnancies; Champion and Thompson in 1951 reported that whenever indications for conization of the cervix are present, this procedure can be done without fear of altering the course of future pregnancies. In 48 cases which they followed only 1 case had dystocia due to the conization, 41 had term pregnancies, 1 premature, 4 Cesarean sections, 1 ectopic and 5 abortions. However; Fischer in 1951 in reporting on the effect of amputation of the cervix on subsequent parturition noted three effects. Namely that there was (1) an increase in the incidence of abortion and premature labor, (2) a reduction in the incidence of conception and (3) a pronounced increase in labor complications. Seven of his patients had 23 pregnancies; 21 full term, 1 premature that died and 1 abortion prior to cervical amputation. Following the amputation these women conceived 14 times, only 3 had full term pregnancies, 4 had prematures that died and 7 aborted. The incidence of successful pregnancies was reduced from 91% to 21.5%. The Cesarean section rate increased from 0 to 57%, and the only living babies were delivered by section. In all 3 vaginal deliveries he reported a prolonged first stage with resultant stillborn babies or first day neonatal deaths. Fischer condemns amputation of the cervix during the childbearing age and advocates the Stuhmrdorf

trachelorrhaphy as a safe alternative. Gorden in 1952 reported that patients with Manchester operations generally had little or no difficulty with subsequent pregnancies.

Duhrssens incisions were performed for the first time in 1887. They were very popular until quite recently. With the advent of the antibiotics and greater safety of Cesarean section, many patients who now have Cesarean section would have had Duhrssen's incisions and difficult mid-forceps deliveries under certain prevailing conditions. In 1936 Hunt and McGee reported that the incidence of Duhrssen's incisions at the Chicago Lying-in Hospital from 1917-1932 was 1.48%. They reviewed 158 cases subsequent to Duhrssen's incisions. Nineteen had Cesarean sections chiefly because of a previous dead baby. Only 6 (4%) had serious cervical dystocia from the scar and those were overcome by 3 Cesarean sections, 2 repeat Duhrssens and 1 manual dilatation of the cervix. They further reported that subsequent labors were short with an average of 9.9 hours.

Today the incidence of Duhrssen's incisions is approximately 0.1% or less. In 1951 Mayes reported an incidence of 1:1078 deliveries at the Methodist Hospital in Brooklyn. Our incidence for the year 1952 at the Evangelical Hospital of Chicago was 1:1109 deliveries. (Table 1)

TABLE 1  
DUHRSENS INCISIONS  
AT  
EVANGELICAL HOSPITAL  
CHICAGO, ILL.

Year	No.	Deliveries	Ratio
1948	13	2309	1:178
1949	10	2285	1:229
1950	4	2334	1:583
1951	3	2337	1:779
1952	2	2218	1:1109

Table 2 reviews those patients who had Duhrssen's incisions and who returned subsequently for delivery. These cases were under the management of the attending obstetrical staff of the

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TABLE 2  
PARTURITION FOLLOWING DUHRSSSENS' INCISIONS

	Wt. of Baby	Hours of Labor	Operation for Delivery	Parity
1. Mrs. K	8# 4 ozs.	28	Scanzoni ROP to ROA (Midforcep)	0
	9# 5 ozs.	4	Normal Spont. Delivery	
2. Mrs. R	10# 6 ozs.	54	Midforceps (Spont. rotation ROP to ROA)	0
	Twins	14½	#1 Breech #2 Version & Ext.	
3. Mrs. E	6# 15 ozs.	44	Midforceps rotation ROP to ROA	0
	7# 4¾ ozs.	4	Normal Spont. Delivery	
4. Mrs. M	6# 10 ozs.	45	Midforceps rotation LOT to LOA	0
	5# 8 ozs.	2	Normal Spont. Delivery	
5. Mrs. S	8# 6½ ozs.	49	Midforceps rotation LOT to LOA	0
	8# 1½ ozs.	6	Normal Spont. Delivery	
6. Mrs. P	7# 6 ozs.	47	Midforceps rotation ROT to ROA	0
	9# 7 ozs.	9	Normal Spont. Delivery	
7. Mrs. Z	9# 2 ozs.	34	Midforceps rotation LOP to LOA	0
			Cesarean Section for Placenta Pr.	
			Repeat Cesarean Section	
8. Mrs. W	8# 1¾ ozs.	78	Midforceps (Manual rot. LOP to LOA)	0
	Twins	12	#L NSD #2 NSD	
9. Mrs. V	9# 10 ozs.	66	Midforceps rotation ROT to ROA	0
			Cesarean Section for Placenta Pr.	
10. Mrs. K	6# 9½ ozs.	50	Version & Ext., failed rotation (ROT)	0
	6# 7 ozs.	9¾	Version & Ext., Rupt. uterus, Hyst.	
11. Mrs. B	6# 7½ ozs.	46¾	Midforceps (LOA)	0
	7# 14 ozs.	5¾	Normal Spont. Delivery	

AVERAGE FIRST LABOR — 49 hrs. 4 mins.

AVERAGE SUBSEQUENT LABOR — 7 hrs. 24 mins.

Evangelical Hospital of Chicago. It is noted that all Duhrssen's incisions were performed in primigravidas. All but one of these had cephalic presentations other than occiput anterior, and that there was a higher than average incidence of occiput posteriors. This is easily understandable since many of these labors became arrested in the mid-pelvis when the head had undergone either little or no internal rotation. Practically all labors were terminated when the head was in the midplane, necessitating rotations and mid-forceps deliveries. These infants were noted to be slightly larger than average in weight. Average length of labor — first labor 49 hours 4 minutes. Average length of labor — subsequent labor 7 hours 24 minutes. From the above we noted that subsequent labors were average to slightly less than average in length, with no unusual features.

Included in this study were patients who had Stuhmrdorf trachelorrhaphies. It must be pointed out that there is a decided difference between Stuhmrdorf trachelorrhaphy and a cervical amputation. The Stuhmrdorf trachelorrhaphy is

merely an excision of the exocervix and does not impinge upon the area of the internal os of the cervix. This is not the case however with a cervical amputation. As was pointed out previously Stuhmrdorf trachelorrhaphy has been advocated as a safe alternative to cervical amputation. Even though the incidence of Stuhmrdorfs has decreased in the past few years — we still see these patients presenting themselves for obstetrical care. Though our series is small we were able to follow 7 patients who became pregnant following Stuhmrdorf trachelorrhaphy. Four of these aborted with pregnancies of 18 weeks or less. One had 2 full term pregnancies each labor being 6 hours 40 minutes and 6 hours 17 minutes respectively. One had a full term pregnancy with a 4 hour labor, and 1 had a premature (29 weeks) 3#7ozs baby with a labor of 2 hours. Another patient is now pregnant 20 weeks. Here again we noted labors that were less than average in length. We were very much surprised to note incidentally that the number of abortions was so high. Possibly the original operations on these patients were more extensive than the Stuhm-

dorf trachelorrhaphy they were reported to have undergone. Invasion or impingement upon the internal os of the cervix may have occurred. Speculum examination of these patients immediately after delivery revealed no lacerations or bleeding from the old operative site.

#### SUMMARY AND CONCLUSIONS

1. Eleven patients with previous Dührssen's incisions were observed in subsequent pregnancies. After an average first labor of 49 hours 4 minutes, subsequent average length of labor was 7 hours 24 minutes.

2. It was noted that all but one of these patients requiring Dührssen's incisions of the cervix had cephalic presentations other than an occiput anterior, and the babies were found to be slightly larger than average in weight.

3. Patients who had Stuhmrdorf trachelorrhaphies and subsequently became pregnant,

were found to have labors that were less than average in length.

4. An incidental finding was that the abortion rate was higher than average in patients with previous Stuhmrdorf trachelorrhaphies.

5. In general, patients with previous Dührssen's incisions or Stuhmrdorf trachelorrhaphy offer no outstanding labor or delivery problem to the physician, in subsequent pregnancies, if they are successful in carrying the fetus to viability.

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## THE ADVANTAGE IN BEING A G-P

Seventy-one percent of the young board diplomate surgeons who were questionnaired stated that they did not have satisfactory charity or teaching hospital connections, and 34 per cent had no charity or teaching hospital appointments. Obviously, their extra time cannot be accounted for on the basis of teaching or care of charity patients. Of course they may, without jeopardizing their surgical standing, spend their extra time at playing golf, building houses, raising cattle, etc. It does seem illogical though, in this age of recognized doctor shortage, that a young surgeon who does one hundred majors a year stands to forfeit his surgical specialty standing by utilizing the remainder of his time in general practice, especially since this confrere who likewise does one hundred operations annually can spend the rest of his time doing research, racing cars, golfing, ranching, etc. without any question raised whatsoever about his eligibility for Board or Col-

lege membership. It certainly is the height of poor logic to single out general practice as the only thing a specialist must not do with his extra time while waiting to become satisfactorily busy in his chosen specialty. The fact is, and this will be categorically refuted or evaded by 95 per cent of surgical spokesmen, that the above mentioned surgical societies have failed to recognize that the only valid and logical reason for requiring 100 per cent specialty practice was to separate the pseudo from the bona fide specialists during the developmental years of the various specialties. Now that the training programs in surgical specialties are well organized and delineated and the medical profession in general has learned to differentiate between competent and incompetent specialists, the need for this requirement has ceased to exist. *J. Ray Thomas, M.D., The General Practitioner and the Surgeon. GP May 1954.*

# Fractures Around the Neck of the Femur

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So much has been written on the subject of femoral neck fractures during the last decade that it is not necessary to present the history of internal fixation except in passing. Throughout the years since Smith-Peterson popularized internal fixation as a standard method of treatment the literature reveals that there has been a constant search for the type of fixation or method that will more closely approach the ideal. The ideal is that method which will hold the fractured bone fragments rigidly in perfect position with no interference in the normal physiology of bone healing. A large number of different methods and types of fixation instruments have been presented — nails, screws, bolts etc., and they have all had one common aim, the mechanical fixation of the fracture with a minimum of trauma.

We all agree that internal fixation is the treatment of choice, providing as it does, relief from pain and discomfort, ability to move freely in bed, and early ambulation. Recognizing then the value of good internal fixation, we must review our experience with this type of treatment and evaluate our results. By checking the available statistics I have been impressed with the thought that our results are not nearly as good as they should be. In 1941 the Fracture Committee of the American Academy of Orthopedic Surgeons reported as follows:

1. Non-union occurred in 41 out of a series of 173 cases, or 23.7%, which met the committee requirements for classification as good reduction; that is, anatomic replacement of fragments or a slight valgus position.

2. Arthritic changes were observed in the femoral head following bony union in 43 out of 157 cases, or 27.3% following fixation with Smith-Peterson nails or multiple wires.

H. B. Boyd and I. L. George reported the following results of internal fixation in 1947, in a series of 300 cases of acute trans-cervical fracture:

Non-union .....	13.5%
Aseptic necrosis .....	33.6%
Arthritic changes .....	33.6%

\*Deceased.

From these figures which are fairly universal we can make several deductions:

1. End-results are gradually improving.
2. End-results are still far from satisfactory.
3. The various factors involved in femoral neck fractures must be carefully evaluated in every case.

Some of the causes of bad results can be summarized as follows:

1. Inadequate reduction.
2. Inadequate fixation, with resulting shearing.
  - a. Insertion of pin or screw in outer third of femoral head.
  - b. Pin or screw too long or too short.
  - c. Failure to produce valgus pedestal for the femoral head.
3. Infection.
4. Circulatory disturbance, with late aseptic necrosis of the femoral head, or absorption of the neck.
5. Too early weight bearing on a bad mechanical line subject to shearing force.
6. Degenerative arthritis with or without bony union.

It is fairly obvious that very little can be done about some of these causes of poor end-results, but it behooves us to carefully consider all of the factors involved in the treatment by fixation and evaluate the various methods of fixation so that those factors within our control are correctly interpreted and the basic fundamentals of treatment followed meticulously.

The basic factors to be considered in femoral neck fractures can be divided into two groups. The first group includes

1. The injury itself, together with the extent and severity of trauma at the site of fracture.
2. The type of fracture, and whether or not a valgus pedestal need be or can be obtained in the fixation in order to overcome the shearing force.
3. The site of fracture and its probable effect on the blood supply to the proximal fragment.

4. The general physical condition of the patient.

The second group deals with the treatment itself, and includes

1. Reduction
2. Immobilization
3. Thorough understanding of the physiology of bone healing.
4. Selective use of the proper method of fixation.

In the first group the injury itself must be appraised—the probability of circulatory destruction within the bone considered, the extent of soft tissue damage estimated, and the general effect on the patient determined. A more severe injury will naturally produce more severe traumatic shock, and a large hematoma must be dealt with as an entity. Nerve injury and muscle tearing are also possibilities that must be considered. The type of fracture is also an important consideration. Assuming an adequate blood supply, the abduction type invariably goes on to union because it lacks the danger of a shearing force. On the other hand, in the adduction type there is a constant shearing force, and unless adequate immobilization is obtained preferably in a valgus position a traumatic reaction may occur with shearing, and a bad result follows. If this adduction type is recognized, proper placing of the pin or screw will do much to offset the shearing force.

The site of fracture is particularly important in evaluating the probable damage to the blood supply. The more subcapital the fracture, the less vascularity, the poorer the healing, and the more important becomes early reduction and fixation with a minimal demand on the physiological process of healing. As the fracture site approaches the intertrochanteric area there is correspondingly less danger of inadequate blood supply, and therefore better end-results may be expected. Injury to the blood supply of the proximal fragment is of course the most common cause of aseptic necrosis. The general physical condition of the patient is obviously also an essential factor. Shock, cardiac pathology, diabetes, nephritis, arthritis and all other conditions must be ascertained and evaluated.

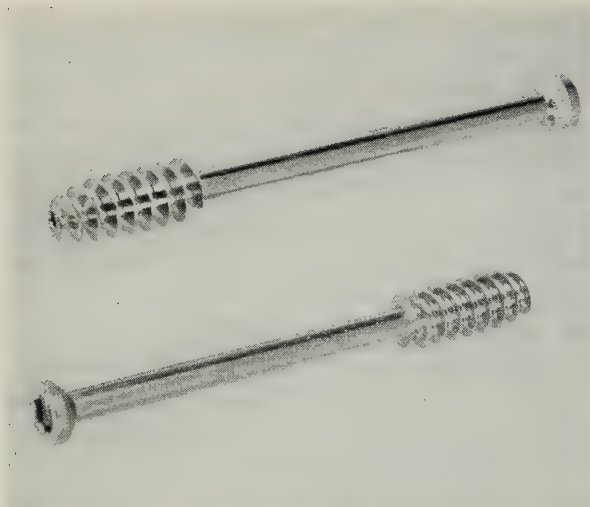
The second group of factors deals with treatment and its effect on bone healing, and is almost entirely within our own control, and the impor-

tance of these factors cannot be over-stressed. The first factor is reduction, and throughout the voluminous literature already written on the subject of femoral neck fractures there is universal agreement that accurate reduction is most important and **MUST** be secured. In fact, one author presenting a paper in 1949 makes the statement "All fractures with proper reduction unite properly; all failures except those of aseptic necrosis were inadequately reduced". With accurate reduction the irregular fracture surfaces of the two bone fragments are in exact apposition, and then the second factor of this group presents itself—that of rigid immobilization.

Rigid immobilization without increase in trauma at the site of fracture must be obtained by the surgeon and therefore the method of fixation must be selected with this factor in mind. Any method that will hold the two fragments in rigid apposition and preferably without forcible impaction will prove satisfactory. *Forcible* impaction, which is generally conceded to aid bone healing in most other fractures, may delay the physiological process in femoral neck fractures because of the impairment of blood supply following a fracture in this region, and thus cause non-union.

The third factor in the second group deals with the physiology of bone healing, and a thorough understanding of this process is essential in selecting the right method of treatment. With the occurrence of a fracture there is some immediate tissue death and hemorrhage in the surrounding soft tissue as well as in the bone fragments. In a matter of a few hours the reaction of inflammation begins and we have a stagnation and engorgement of the surrounding vessels and capillaries, lymphatics, and soft tissues. The hemorrhagic blood and dead tissue cells create a marked lowering of the pH in the local tissue fluids which continues until the dead cells are absorbed and the minute and impaired circulation can carry them away. A fibrin network is also formed in these early hours of bone healing, by the clotting of the hemorrhagic blood and the exudate. Progressive decalcification of dead and injured bone cells continues *as long as the tissue fluids continue a low or acid pH, which in turn inhibits and postpones phosphatase activity.*

A growth of undifferentiated connective tissue cells begins along the fibrin network, joining the bone ends like a framework. With the disperse-

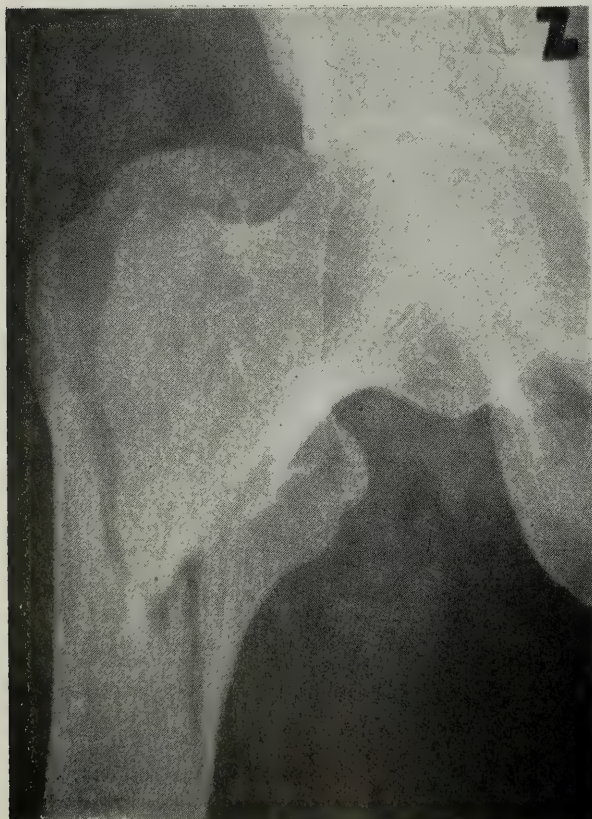


**Figure 1. Lundholm Surgical Lag Screw.**

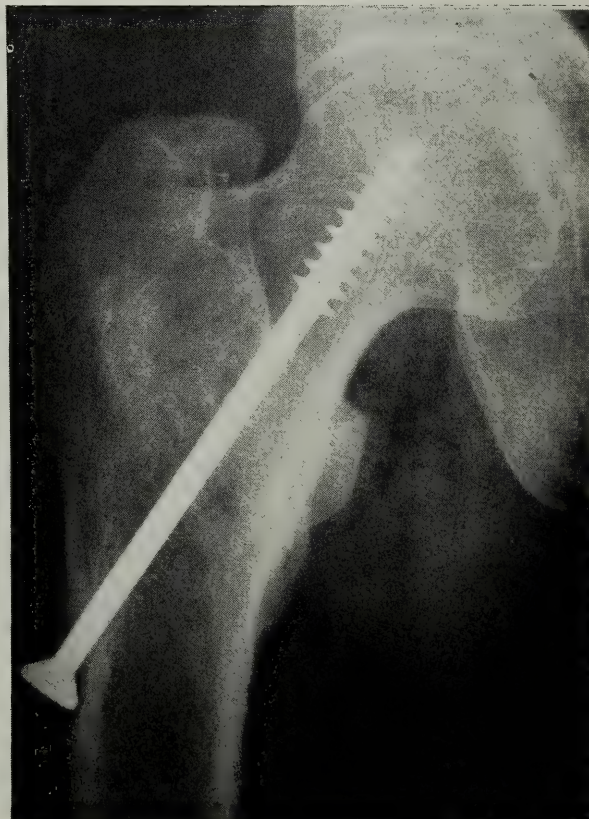
ment of the autolyzed products of local tissue metabolism the pH rises to a point where phosphatase activity can begin, and then eventually callus formation occurs. There seems to be adequate support for the belief that if the new tissue becomes differentiated into adult formed connective tissue before the pH of the tissue fluids has risen to a point where phosphatase activity is possible, no calcium deposition occurs and fibrous

union results. If the pH rises to a point which permits only minimal phosphatase activity a slow calcium deposition occurs, but ceases as a local healing process when tissue differentiation is complete. It would seem logical, therefore, to assume that forcible impaction in the presence of impaired blood supply, either traumatic or as a result of the fixation technique, would tend to continue a lowered pH by increasing the amount of dead tissue cells to be carried away, beyond the time limit for good phosphatase activity, and thus increase the danger of fibrous union or non-union.

Finally, the selection of method of fixation must be done with full realization of all of the above factors. A number of years ago I devised a lag screw for internal fixation of femoral neck fractures which has proven to be eminently satisfactory, and comes closer to meeting the requirements of the various factors involved in femoral neck fractures than any other fixation instrument. This lag screw, illustrated in Figure 1, is a simple one-piece lag screw and is cannulated for insertion over a guide pin, and the technique of insertion is within the ability of all surgeons.



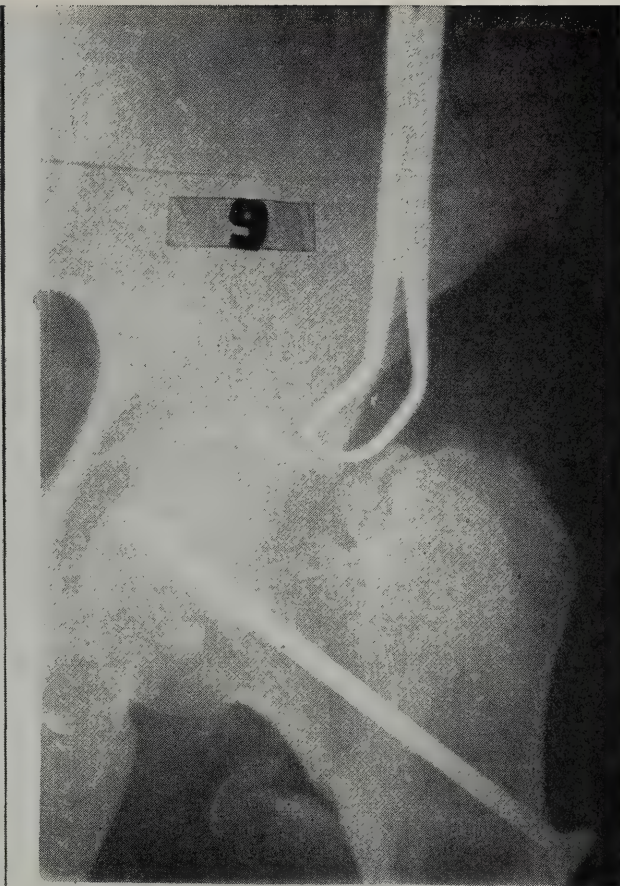
**Figure 2a: Typical Intertrochanteric Fracture.**



**Figure 2b: End-Result following fixation with Lundholm Lag Screw.**



**Figure 3a: Low Transcervical Fracture.**



**Figure 3b: End-Result following fixation with Lundholm Lag Screw.**

With accurate reduction of the fracture the lag screw is inserted with the minimal trauma and when tightened down so the lag screw head bearing against the cortical shaft of the femur is holding firmly against the pull of the wide threaded portion which is entirely within the femoral head or proximal fragment, the two fragments are drawn together and held immobilized in rigid apposition. This is illustrated in Figure 2 and Figure 3. The irregular fracture surfaces of the two fragments held rigidly in apposition also prevent rotation of the proximal fragment. No additional trauma has been incurred in this procedure, and no forcible impaction has been necessary. Therefore, the physiological process of bone healing has neither been delayed nor interfered with, and early phosphatase activity may be anticipated with resulting bony union. I am listing below a summary of my own experience in a series of seventy consecutive cases in all of which I used my lag screw. With the end-results achieved I am convinced that this instrument fulfills the requirements of internal fixation of femoral neck fractures more ideally than any

other fixation instrument heretofore presented.

**CONCLUSIONS:** Experience in internal fixation of femoral neck fractures emphasizes the need for improved results. To this end the fundamentals of treatment must be adhered to as follows:

1. Accurate reduction of the fracture must be obtained.
2. Proper placement of the fixation instrument with subsequent rigid immobilization.
3. Minimal trauma with no delay in normal physiology of bone healing.
4. Selective use of proper type of fixation instrument.

#### ANALYSIS OF CASES

Total number of cases in series	70
Subcapital fractures	9 (12. 8%)
Transcervical fractures	34 (48. 6%)
Intertrochanteric fractures	27 (38. 6%)
Number of cases with absorption of neck and subsequent recovery with bony union	5 ( 7.14%)
Number of cases resulting in non-union	2 ( 2.85%)

Deaths from intercurrent conditions .....	3 ( 4.28%)
Deaths attributable to fracture or fixation .....	0
Total recoveries with good function .....	65 (92.83%)

In the cases resulting in death, one was a white woman age 78, who had nephritis, myocarditis and marked fibrillation on admission, and died a cardio-renal death on the ninth day. The second was also a white woman age 75 who had hypertension and diabetes mellitus. Following fixation she was up in a chair for several weeks and seemed to be improving. Three weeks after fixation she went into diabetic coma and died. The third case was that of a 77 year old white male who had nephritis and marked hypertrophic prostatitis upon admission and was wearing an indwelling catheter. Following fixation he seemed to do well, but one week later cardiac decompensation occurred and he died a cardio-renal death.

One case of bone absorption required a reconstruction operation, with subsequent bony union. Another was a 76 year old male in whom a bone graft was subsequently implanted, and he also developed bony union after eight months. In the two cases resulting in nonunion, one was a woman with advanced arthritis who refused any corrective procedure, and she remains an invalid. The other case was also a woman who refused corrective procedure, and is apparently content to get along in a wheel chair. One interesting case was a white male 91 years old who had myocarditis and a markedly hypertrophied prostate on admission. On the second postoperative night he jumped out of bed and walked around the

ward unassisted, disrupting the reduction. Fixation was again accomplished, three weeks later a cardiac decompensation occurred and brought under control, and four weeks following this transurethral prostatic resection was done. He is now completely recovered, some two years later, and walks with no support.

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# The Contribution of Psychiatry to the Practice of Medicine

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The contribution of psychiatry to the practice of medicine will depend upon the quality of the teaching in undergraduate medical education. The Group for the Advancement of Psychiatry had the following to say on this subject: "If medical treatment is to become comprehensive, the teaching of medicine from its very beginning, should be kept as close as possible to the person, the total human being. During his undergraduate years, the student should get an orientation of this sort which will last his lifetime. To this end, he should see and study people from the first year on. There are psychiatric implications in the care of every patient, and every fraction of clinical experience should be viewed with the broad generalizations of dynamic psychiatry in mind. The special function of the department of psychiatry in this connection is to give the student an understanding of the patient as a person, to give him some knowledge of the techniques necessary for relating himself to the patient so that he arrives at such an understanding, and to develop in him at least some minimum ability to use this knowledge consciously for the patient's benefit, whatever disease or disorder the patient may have."

The two lengthy conferences on psychiatry in medical education which were jointly sponsored by the Association in 1951 and 1952 are examples of collaboration between psychiatry and medicine which may prepare for the reorganization of medical education. These conferences brought together deans of medical schools, professors of psychiatry and representatives of the American Medical Association in the field of medical education. The report of the first conference on Psychiatry in Medical Education has been published and the information regarding the second one will soon be available. These meetings, which are of momentous significance for the progress of medicine, represent an effort

to bring the standards of medical education into keeping with present-day scientific knowledge regarding the psychological factors in illness which are so prevalent in western civilization. The acquisition of this knowledge during undergraduate medical education and residency training is essential for its proper utilization in the practice of medicine. To lecture about it to physicians whose medical training has been restricted to physical-chemical-bacteriological conceptions of illness and who have been in practice for several years is far from satisfactory because lecturing is the least effective method for reorganizing attitudes toward people. Opportunities for daily clinical presentations with as much participation by practicing physicians as by their teachers are as rare as the experiences of the psychiatrists and their medical colleagues during the last war.

The pilot course in Psychotherapy in General Practice at the University of Minnesota in 1946 was unique in the history of medicine and psychiatry. It is the protocol of an experiment in post-graduate medical education. Similar courses of practical instruction might be established through the collaboration of State Medical Societies with University Medical Schools.

Somewhat similar opportunities for practicing physicians to acquire a working knowledge of the psychiatric aspects of illness and practical methods for their treatment will become available when departments of psychiatry become established in general hospitals. Psychiatrists will then have opportunity to make ward rounds with internists, surgeons, and all other practitioners of medicine. The day-to-day sharing of knowledge and exchange of ideas will be valuable for everyone concerned and will be equally applicable in the care of ambulatory patients. These were the experiences which psychiatrists and their medical colleagues shared together in the military hospitals in World War II. The general medical and surgical hospitals of the Veterans

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Administration regularly maintain departments of psychiatry and the general civilian hospitals can no longer afford to be without them if they are to provide adequate medical care for the treatment of the people in the communities who support them.

Following the example of medicine, psychiatry has become fragmented into a number of specialties and the American Psychiatric Association which has almost doubled its membership since 1945, has fifteen standing committees on the technical and community aspects of psychiatry. There are those who devote themselves to child psychiatry, to public health, to industry, to medical education, to research, to mental hygiene, to academic education, to the armed forces and to other departments of government. This does not include the large number of psychiatrists in private practice, in hospitals and in clinics. These developments, which are indicative of the progress of psychiatry, are each contributing to the larger problem of medical care. The *great* progress in psychiatry, however, will not take place until the knowledge and techniques it has acquired become useful to every practicing physician. This knowledge includes the personality of the physician as well as the personalities of his patients because the practice of medicine invariably includes the doctor-patient relationship. In many illnesses this relationship is as important for restoring patients to health as technical knowledge and skill which physicians ordinarily employ. In some illnesses it is more important. This fact is well known and is demonstrated in the everyday practice of medicine.

Every physician practices psychiatry whether he knows it or not and psychotherapy begins when a patient comes to a physician for the first visit. Every doctor knows that each patient reveals much information about himself of which he is unaware. He does this in his speech, in his tone of voice, his posture, his gestures, his countenance, his attire, and in many other subtle ways. This information is of value in learning to know the patient and how much or how little his personality is involved in his illness. Every good physician utilizes this observable data in his study and his treatment of his patients. What is frequently forgotten is that physicians *also* reveal much about themselves of which they are unaware to their patients. To the extent that a

physician can maintain as much awareness as possible of himself during his examinations and treatments of his patients to this extent will he avoid the mistakes which interfere with his efforts to relieve their suffering.

Many patients go to their physician for the first time with faith and confidence in his ability to help them. They invest their doctor with the wisdom, the authority and the power they once attributed to their parents. They seldom express their feelings but they often manifest them in their attitudes. The physician has the highest obligation to maintain the confidence which his patients have in him in order that he may exert an optimum effectiveness in treating them.

In seeking the advice of a physician every patient is as helpless and dependent as he was in his childhood when he turned to his mother for relief from his pain. Every doctor-patient relationship is a re-enactment of the parent-child relationship. The more aware a doctor can become of this fact the better will he understand and the more he will be able to help his patients.

The good physician, like the good parent, listens patiently, remains calm and regards the patient with the same respect he would like to be shown were he in the place of the patient. He does not permit the patient to ramble endlessly because he must conserve his time. He does not hesitate to ask any questions which seem relevant. In addition to the history of the present illness he attempts to learn what he can of the patient's social circumstances, particularly his relationships with his family. He also needs to know about the patient's work and how he gets along with fellow-workers and with his boss. During the first visit of the patient the physician may do nothing more. His first effort is to familiarize himself with the nature of the patient's illness, how he lives with his family, how he feels about his work and how he gets along with others. At this time the physician makes tentative appraisals of the patient's disposition, his intelligence, his attitude toward himself and his doctor. It is as important to know what kind of person has an illness as it is to know what kind of illness a person has. These are two facets of a whole which are inseparable. The physician is not concerned whether an illness is organic or functional but to what extent it is organic and to what extent it is functional.

This can only be determined through knowing the patient as well as his illness.

At the conclusion of the first visit the physician avoids making any promises except the promise to see the patient again as soon as possible. He needs to learn more and he does not profess to know more than he does. Throughout his treatment of his patient he is as honest as possible and never hesitates to acknowledge that he does not know or that he does not understand. If the patient expresses his own opinion about the diagnosis or the treatment of his illness the physician does not take umbrage because he is aware of the vast amount of medical information which is available to lay persons and he remembers too how he was wont to diagnose his own symptoms during his years as a medical student. In his relationship with his patient the doctor avoids talking about himself, his family, his friends and other physicians. He avoids assuming an artificial attitude of authority or one of omniscience and he accepts any justifiable criticism of himself or his nurse which his patient may make. He is never afraid of his patient. Not being afraid, he does not need to yield to requests which his patient may make and with which he does not feel in accord. His patient may express momentary resentment but

will simultaneously experience renewed esteem and confidence in his physician.

Whenever it is possible to do so, it is advisable that patients be seen by appointment and on time. When they are required to wait for their physician in his reception room for long periods, they become resentful and correctly assume that he has no regard for the value of *their* time and is solely concerned with his own. The physician will not accept more patients into his care than the number for whom he has ample time. To accept more necessitates less time for each, more visits for each and less opportunity to render optimum professional care.

The physician avoids making predictions about the length of the treatment and remains conservative about the benefits to be derived. Some of the doubts or fears he may have about his patient may be due to his own anxiety rather than to anything his patient feels about him.

It is far more difficult to practice the basic concepts which have been outlined than it is to describe them. They are, however, the psychiatric principles which need to be included in the daily practice of medicine. Some of them are regularly practiced by physicians who have not had the benefit of any psychiatric indoctrination. General Motors Building.

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## NEWER ANTIBIOTICS

Two new materials have been described recently, tetracycline and erythromycin. Tetracycline has precisely the same antibacterial spectrum as aureomycin and Terramycin; indeed, chemical formulas for each are remarkably alike. Its singular advantage is that there are fewer gastrointestinal side-effects associated with its oral administration. For specific infections, its dosage is the same and its activity apparently identical with its two chemical brothers. It again is emphasized that chloramphenicol,

aureomycin, Terramycin and now tetracycline do not represent different therapies for infections; rather the use of a second is merely replacement of the first. If one fails, all probably will. Erythromycin is active only against gram-positive organisms. Its activity probably is comparable to that of aureomycin but it is not as potent against susceptible species as penicillin. Organisms rapidly become resistant to it and its place in therapy probably will be limited. *Paul A. Bunn, M. D., A Report On Antibacterial Substances. New York J. Med. May 1, 1954.*

# Teaching Psychiatry in a Medical Curriculum

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Elgin

The report of the Advisory Committee on Internships to the Council on Medical Education and Hospitals of the American Medical Association, published in 1953,<sup>1</sup> devotes considerable space to the experience in psychiatry the young and developing physician is to acquire. Psychiatry as a basic science is considered to be an indispensable part of *all* medicine. Such important aspects as relating to the psychology of acute and chronic illness, of disability, of convalescence and of the physician-patient relationship are considered to be of common concern to all who care for the sick. The authors of the report stress that it is just as important for the physician to understand the justified anxiety a patient demonstrates after developing a cerebral hemorrhage as it is to know the neuropathological changes causing this clinical entity. Knowledge of these matters should be shared by *all* members of the teaching staff and it should be applied to the study and care of *all* patients.

For those of us who are teaching psychiatric personnel and the future generation of general practitioners, in institutions and schools which at the end of the course of many years are charged with the responsibility of releasing young men and women for the practice of medicine, or dealing with people as an overall function, the time has come to take stock. What has psychiatry to offer the medical student and what will the general practitioner have to offer psychiatry?

The above-all prerequisite of the general practitioner is his *understanding of himself*. This is essential because of a frequent dislike on the part of the general practitioner toward the patient with functional complaints for which an organic basis cannot be found. In many instances the student and practitioner are preoccupied with

their own emotional conflicts, of which there frequently are many. Let us remember that a major portion of our psychiatric patients are seen in the early twenties, after post-pubescent problems might have been solved unsatisfactorily, and when new demands make themselves known in the form of social, marital and financial difficulties. The medical student is not immune to these problems; he reacts to them in a manner identical to that of his fellow layman, yet he is expected *not* to project *his* difficulties on his patients, but to understand them and help them. The young general practitioner, in turn, will not only have to know his limitations regarding professional experience and manual skill, but will *also* need a working understanding of his own personality structure. Impatience, and the often misquoted and misinterpreted lack of time, are arch enemies of the understanding of the functional patient who continues to crowd the offices of the general practitioner, and who needs help. The undesirable trend of the general practitioner to act merely as a filing cabinet and rid himself of a case whom he "does not like" by a mere referral to a specialist, without first exhausting diligently his own entire armamentarium, should be corrected *early* during the school years. It is a well-known fact that the patient with functional complaints frequently seeks a physician who has established himself recently, hoping that *he* will finally understand him after many disappointing experiences with others. A referral to a specialist should never be a matter of mere convenience because already the physician is projecting his own personality shortcomings, reasoning that the *patient's* personality delays improvement of whatever condition is under treatment. "Perhaps some one else will have more luck with *him*" is an easy way out of admitting "*I do not understand him now but I will as time goes by, as I create the proper attitude in myself toward him and thus create a better relationship*".

This is a heroic admission for which the fu-

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Read at the 113th Meeting of the Illinois State Medical Society, Chicago, Illinois, on May 19, 1953.

ture physician has to be prepared early. A broad discussion of so fundamental and elementary an issue as the mental mechanisms found within the first chapters of every good textbook on psychiatry will be extremely revealing and rewarding. From the beginning, the student will be inclined to identify himself with many of the examples used in explaining human behavior, and it is most stimulating to see the student give practical examples of the application of the mechanisms which are to protect and to adapt the human personality. That these examples in most cases will be based on personal experiences, at other times will be strong identifications with persons close and important to him, is evident, but nevertheless gratifying.

Far from attempting to prepare the student to be a full fledged psychiatrist, we cannot help but feel that much remains to be done to create the proper attitude toward emotional illness. For this, a short discussion of the *history of psychiatry* is indispensable. But a mere discussion of the facts will not suffice. Neither will it be satisfactory just to indicate the importance of cultural factors in the development and in the understanding of mental illness.

The student has to be shown that the very way psychiatry has been practiced through the course of the centuries has been a direct expression of the preoccupations of the *general population*.<sup>2</sup> Toward the end of the Middle Ages, the insecure and threatened authorities in power had no better way to protect themselves, and their subjects, from human beings expressing unhealthy imaginative ideas and grandiose thinking, than by burning them to death. The French Revolution, with the liberation of the individual, went hand in hand with freeing—literally—the insane from his chains. Psychiatry in Central Europe after the Franco-Prussian War embarked on classification, fulfilling the general desire to create order after a victorious struggle.—Today, after two global wars, man feels that there still remains much to be done about human relationships and, what is more, he feels that wars are no longer, or should be no longer, the solution to interpersonal disputes. Hence the avid desire to understand his fellow man has come into the fore. This cannot be accomplished by burning the opponent to death, or by classifying his illness properly, nor by waging war against him. Dy-

namic psychiatry had been born before, but not too long before, the outbreak of the first World War. It has never enjoyed more popularity than during the present days, after the futility of war has been fully realized. The student rapidly identifies himself with present day concepts and assumes his place eagerly, in the end benefiting himself and his patient by approaching him in the proper frame of mind.

The student frequently feels that psychiatric treatment methods and their results are not as glamorous as a life-saving surgical operation, not as spectacular as the treatment of a once deadly infectious illness with antibiotics, and not as gratifying as being of assistance with the birth of a new life. But he will never have a better opportunity to observe human emotions than before, during and after a delivery. Mother, father, siblings, and the newborn himself will offer a conglomeration of joy, fearful expectancy, love, disappointment, hate and enthusiasm hardly ever displayed simultaneously by so many belonging to one group. The emotions the student observes in giving assistance to a birth are so common in everyday life, and play such an important part in creating emotional disturbances, that this experience becomes invaluable to the future practitioner.

It cannot be emphasized enough that psychiatry joins ranks with the other specialties in being *life saving*, the primary goal of all art of healing. Apart from giving new hope to the depressed, new courage to the desperate, of returning the psychotic to a life of meaning and reality, it may prevent the homicidal from accomplishing his antisocial act, and the suicidal from terminating his own life. What greater, what nobler task is there for the physician, in addition to helping create and preserve a life, than to prevent death?

Psychiatry, in the mind of the student and the general practitioner, is still at times associated with, and restricted to, huge buildings in which the mentally ill are confined, the psychiatrist being more or less their keeper, or a general practitioner for the mentally ill at his best. Once the gate of a mental institution has closed behind the patient, his fate is sealed. A general atmosphere of hopelessness and inactivity still prevails at times then in the mind of the family, and even the referring physician who has, for no excusable

reason, lost interest in his former patient. It is easy to demonstrate to the student the fallacy of these conceptions and the catastrophe which would ensue were these assumptions true. A working knowledge of the methods of treatment in our field, and their indications, should be installed, so that the student will know of their *evistance*, whereas their intricacies and technical application will only be a burden to him.

In this connection it is interesting that from time to time psychiatry has tried to interpose a mechanical device between therapist and patient, and without fail has again and again made serious and honest attempts to return to the pure therapist-patient relationship, currently called psychotherapy. From fire, water, iron, through chemicals, gases and electricity, psychiatry has tried, and continues to try, to bring about improvement in the patient's condition, finally always realizing that these devices are not always mere adjuncts, but at times even wedges driven between patient and therapist. The open-minded psychiatrist considers these mechanical devices as symptomatic treatment at its best. No human being has yet discovered a substitute for a pleasant relationship between two individuals. And it will be well to remember that no mechanical device, be it as delicate or complicated as possible, will ever outrank the *personal feeling* the patient has toward his physician, and vice versa.

It remains paramount to emphasize and re-emphasize the importance of the harmonious interpersonal relationship as such, which fact is tantamount in the living together of only two people in any setting society creates, and the disturbance of which in most instances originates from emotional imbalance of one or both partners. It will be highly enlightening to the student to know that the fundamental drives for food, love, shelter and prestige, and their imprudent, or lack of, control, are at the base of all interpersonal disharmony, be it in the home, the fam-

ily, the community, the nation, and, of course, between peoples. Harry Stack Sullivan in his "The Study of Psychiatry"<sup>3</sup> emphasizes that the theory of gravitational, electric and magnetic fields is much more highly developed than is the theory of *interpersonal* fields. This is partly due to the fact that we have been studying events of this kind much longer than we have factors of the interpersonal relations, because prejudice and preconceptions about the nature of the non-human universe have yielded much more readily to the methods of scientific exploration than have the prejudice and preconceptions about human living. It is important to recognize the personal fields in which one finds oneself and how to influence the field forces in the direction of more adequate and appropriate integration.

It is the cultivation of the harmonious interpersonal relationship of which the student should be aware in *practicing his profession*. It is this relationship from which both will derive *most*, physician as well as patient.

Since time immemorial, suffering man has looked up to, and has expected a degree of omnipotence from, his physician, which he should live up to, at least within his realm of possibility. By an honest and realistic appraisal of himself and his "interpersonal field force" the future physician will be practicing his profession in a more meaningful and a more enjoyable way, for both the patient and himself. Here is where psychiatry will make its contribution and where the physician in turn will pay tribute to psychiatry.

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# Corneal Erosions

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All of us are confronted in our office practice, with the problem of corneal erosions and abrasions. Such injuries if managed promptly and vigorously, respond with amazing promptness.

The corneal epithelium is composed of stratified squamous cells, four to five cell layers thick. It has two characteristic features: its mirrorlike surface and the absence of specialized cells. This mirrorlike surface, so essential to good vision, is maintained in part by the continual polishing effect of the lid action, which is aided by the lubrication of lacrimal secretion. This smooth surface is maintained even if the underlying stroma is uneven.

The epithelium is only loosely attached to Bowman's membrane. With gentle massage of the cornea through the lids and observing the cornea with an ophthalmoscope, superficial lines are noted. The actual mechanism which binds the epithelium to Bowman's membrane is not known. No evidence of a cement substance has been demonstrated. It has been demonstrated that trypsin, chymotrypsin, and papain cause separation of the corneal epithelium into individual isolated cells without interfering with its morphological integrity. Amyl and butyl alcohol cause separation of the epithelium from the underlying stroma. This suggests a lipidlike material and that an energetic process is necessary to maintain cohesion.

The slightest corneal injury causes a grayish opacity. The corneal epithelium derives its cells from two sources: migration of the remaining cells and sliding of the limbic conjunctiva over the cornea. The time of migration depends on the severity of the injury. The epithelium regenerates as a single or double layer of cells, that are large and flat. In three to four days this thin layer of cells develops into apparently normal epithelium if the underlying stroma is normal. These migrating cells may be 30 micra as compared to 9 micra of the normal basal

epithelial cell. One of these flattened cells may cover an area over nine times that of the average cell. This epithelial layer is only one to two cell layers thick as compared to the average four or five cells, so that a remainder of 5 to 10 per cent of the cells can cover the denuded area caused by a severe injury. It also has been shown experimentally that in the absence of mitotic activity, the epithelium can heal at a near normal rate by migration.

Mitotic activity of corneal epithelium is inhibited by injury. In the first hour of injury no activity is observed. In the second and third hours, cells surrounding the wound elongate, covering the floor. Morphine, ephedrine, and epinephrine show an inhibitory effect on post-traumatic cell movements, when used systematically. Two local anesthetics, cocaine hydrochloride four per cent and pontocaine hydrochloride one-half per cent have been shown experimentally to inhibit all cell movements. Cell activity is increased with the application of heat. It is necessary to have a fairly normal underlying stroma to maintain this new epithelium. With injudicial cautery, epithelium will heal to the edge or form an unstable bleb. Deep eschars must be removed before a stable epithelium will be maintained.

These patients complain of pain, foreign body sensation, and tearing. Pain may be severe and accompanied by considerable blepharospasm. Often they are in a state of near hysteria. It is wise if possible, to obtain the visual acuity for medicolegal reasons and to reassure the patient; it may be necessary in some cases to instill an anesthetic before this can be accomplished. These people usually give a history of trauma of varying degrees. A common cause is scratching of a mother's eye by an infant. Injuries from twigs, newspapers, pets, and industrial accidents are other frequent sources of trouble.

If fluorescein is instilled first and then a liquid anesthetic, some time and effort can be saved in subsequent irrigations. It is most helpful, if

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not essential, to examine these lesions with the biomicroscope to determine the extent of the abrasion and the status of the epithelium surrounding it. Often a small break will be surrounded by considerable loose epithelium and the epithelium will be rolled on itself, evidently from lid action.

The cornea has been aptly compared to a child by Dr. Swan, and in this instance to spare the rod is to spoil the child. At this juncture we must not temporize and must avoid the use of local anesthetics. Vigorous treatment is demanded. The surgical principles of debridement are mandatory. All loose and rolled epithelium is removed. A small cotton brush on the tip of a fine corneal applicator is made and a wisp of cotton is rolled on the tip of the applicator to form a cotton thread. This thread is cut about two millimeters from the applicator tip, making a small brush effect. The applicator is moistened in normal saline and is used to remove all loose epithelium. The wound edges are now lightly touched with 20 per cent trichloroacetic acid on the cotton applicator.

It is wise to instill a mydriatic to relieve ciliary spasm and in alkali burns, in anticipation of subsequent iridocyclitis. Heerema and Friedenwald have shown that U.S.P. lanolin and U.S.P. petrolatum inhibit corneal healing. Repeated washing of the lanolin apparently removed some toxic component which had inhibited wound healing. It has also been reported that the epithelium has grown over globules of petrolatum, causing recurrent erosion. Removal of the globules resulted in prompt recovery. Solutes diffuse out of the cornea readily but suspensions such as silver proteinates may be retained. In this manner an accidental tattoo may be formed. Metalliclike proteinates break down slowly with toxic effects on the corneal tissue. It is therefore the best plan to use anesthetics sparingly, knowing their drying and inhibitory effects and antibiotics in a fluid vehicle, avoiding the metallic proteinates.

A Wheeler pressure dressing is applied. It may be that the known beneficial effect comes not from partial immobilization and pressure, but from the increased local temperature. As stated earlier, increased temperature increases cell activity. This useful ophthalmological dress-

ing consists of gauze fluffs, or three or four eye dressings placed over the injured eye. First one inch tape strips, six inches long, are placed medially and laterally, to hold the dressings in place. Subsequent tape strips are applied from the outside inward, the last being central. The loose end is placed on the forehead and pressure applied downward. This dressing in uncomplicated cases is removed in 48 hours. If the abrasion is not healed the dressing is reapplied for another 24 hours.

It has been stated that without the opium derivatives few of us would be callous enough to practice therapeutics. Codeine, a time honored ophthalmic analgesic given with aspirin, will control the pain of corneal abrasions. Barbiturates are helpful for inducing sleep.

Knowing that this new epithelial covering may be only one or two cell layers thick and easily detached or damaged, the patient should be cautioned about rubbing or wiping the eye. A lubricant such as artificial tears is prescribed. A slight corneal haze may be present for four or five days.

In view of the popularity of cortisone, it should be stated here that the consensus is that the hormone has no beneficial effect in healing corneal epithelial abrasions.

## SUMMARY

1. Some of the recent experimental developments are reviewed in relation to the physiology of corneal epithelial wound healing.
2. The principles of surgical debridement with the aid of the biomicroscope are stated.
3. A pressure dressing is advocated with the avoidance of local anesthetics as a means of treating these cases. Pain is controlled by systemic medication.

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# Oral Metrazol Therapy in Cerebral Arteriosclerosis

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The ever increasing percentage of aged individuals in our population has virtually changed many of our hospitals for the treatment of mental diseases into custodial homes for the aged. It is imperative that all forces be mobilized to relieve these institutions of such an unintended burden by improving the physical and mental status of these oldsters so that nursing becomes simpler and home care possible.

Home tenancy is one of the best psychotherapeutic measures for these elderly individuals who are lonely and frequently feel (and unfortunately often correctly) that they are not wanted. Institutional life in many cases but fosters this attitude. Thus any form of therapy which can improve the outlook on life of these patients is of value, particularly if it can be more or less easily carried out.

Medical science has prolonged life. It is now its duty to see that this prolongation of mundane existence represents more than a slow vegetative decay.

Since the first paper by Chesrow et al. in 1951 on the good results achieved with oral Metrazol in 32 severely confused senile patients, other reports have corroborated the effectiveness of this use of the drug as an analeptic, restorative, and general tonic. (Smigel et al., Fong, Seidel et al., Levy, Lieberman, Andosca, and others)

As a result about 1½ years ago I started a group of 15 patients on oral Metrazol for a period of 90 days. The results were encouraging in a fair percentage of these elderly individuals

as regards improvement in both the physical as well as the mental status. Unfortunately, however, due to external circumstances exact records could not be kept.

The present report deals with a further group of 19 patients, aged 51 to 100 years, with a mean age of 73 years, treated with oral Metrazol. Originally 25 were selected but 6 died before conclusion of the study.

The diagnosis in all of these cases was cerebral arteriosclerosis and mental confusion with or without actual psychotic symptoms. Fourteen patients were regarded as psychotic, while 5 showed no psychotic symptoms. One patient was originally mentally deficient.

Preliminary to the start of the medication all patients were given a physical examination as well as blood counts, hemoglobin determinations, urine and Kahn tests, blood pressure readings, as well as electrocardiograms. Basal metabolism rates were also done.

It seems unnecessary in this report to devote much space to the rationale of the Metrazol therapy. This has been done adequately by the authors previously cited. I am in full agreement with their findings that Metrazol represents a safe and effective analeptic of low toxicity, which acts particularly on the medullary centers: Respiratory, vasomotor and vagal, and on the cortex.

Treatment in my cases was started routinely with 3 tablets (gr. 4½) of Metrazol four times a day for the first 30 days, followed by 2 tablets (gr. 3) four times a day for the next 30 days,

and further observation for another 30 days with a maintenance dose of 1 tablet (gr. 1½) four times a day.

In only one case did this initial dose of gr. 4½, four times a day lead to untoward effects represented by excitement and restlessness. Treatment was therefore continued with only 1 tablet (gr. 1½) four times a day. It may be mentioned here that is one of the 6 cases that did not improve.

In all the cases in which Metrazol therapy led to improvement a change for the better was seen within the first 30 days. The earliest improvement was noticed in the patient's appetite and sleep pattern — to be followed quickly or more gradually by better adjustment to environment and conformity toward rules, better cooperation, better orientation, as well as decreased tension and anxiety. Toilet habits and untidiness improved, when improvement occurred at all, but none of the consistently untidy patients became entirely tidy. Bedridden patients, who had been bedridden for years showed no improvement. Destructive and aggressive patients were not included in the studies, since it was felt that regular medication in such patients would meet with difficulties.

Of the 19 cases followed: 6 remained unchanged; 2 showed slight improvement, that is, one or two of the defects originally present improved. This was mostly noticeable as far as appetite, sleep, and orientation, in this sequence, was concerned. Nine patients evinced moderate to good improvement; here the majority of the defects improved. Two were considerably improved, their entire attitude changed, they made themselves useful in the ward and took interest in others. Five of these oldsters improved to such an extent that they could have been cared for at home had conditions there permitted this. One of these two, incidentally, is our "Senior," one hundred years old.

It was found that improvement occurred in those patients who showed no psychotic symptoms as well as in those who did. However, of the much improved cases 3 showed psychotic manifestations.

Only one of my cases showed a change in the blood picture. Here a hypochromic anemia was present at the first examination. At the end of the treatment the blood picture was normal. In

all the other patients the blood picture was not affected, nor did the other laboratory tests show significant changes.

In 13 cases the blood pressure dropped during therapy and this was true whether it had been high or normal before. The systolic pressure was more affected than the diastolic, falling more than 30 mm. of Hg. in some of the hypertensive cases. In 4 patients the blood pressure remained practically unchanged, in 2 it was somewhat higher at the end of 90 days.

As an illustration of the good results seen after three months of oral Metrazol therapy, I offer brief abstracts of 3 case histories:

Case 1. S.M. — 60 year old man, classified as psychosis with cerebral arteriosclerosis. Blood pressure before medication 180/95. All laboratory tests essentially negative. Appetite fair, sleep poor, answers only after much prodding, remembers vaguely events before 1935, after which his memory is a complete blank. Disoriented as to his name, place and time. Unable to walk. After 90 days of medication, blood pressure 150/90, appetite good, sleeps well, now knows his name, the name of the institution, the month of the year, and day of the week. He is able to find his way to the toilet by holding on to beds and walls.

Case 2. G.W. — 60 year old man, classified as organic brain disease, without psychosis, cerebral arteriosclerosis and right sided hemiplegia. Blood pressure 160/70, electrocardiogram definitely abnormal. He is a deaf-mute and not able to communicate, is untidy at times, bedridden. After 90 days of medication patient tidy, more alert, eats and sleeps better, able to communicate by sign language, gets around in a wheel chair. Blood pressure 145/80, electrocardiogram unchanged.

Case 3. C.R. — 100 year old man, classified originally, many years ago, as alcoholic psychosis. No sign of psychosis in evidence at start of treatment. Diagnosis — cerebral arteriosclerosis. Laboratory tests essentially negative. Blood pressure 120/70. Disoriented, memory defects, simple questions are answered correctly, tidy, able to be up and around at times, idle. After 90 days medication, laboratory tests and blood pressure the same as before. Orientation now has improved considerably, he knows his name, name of the institution, and time of the year. He is up and

about most of the time, friendly, cooperative, makes himself useful on the ward by folding linen.

Summary: In a group of 19 male patients, with the diagnosis of cerebral arteriosclerosis with or without psychosis, Metrazol in tablet form was given over a period of 90 days, starting with a relatively high dose of 18 grains daily for 30 days; going down to 12 grains daily for the next 30 days; and continuing with a maintenance dose of 6 grains daily for another month. Except in one case the higher dosage was well tolerated.

The majority of the patients showed some improvement; from slight to considerable. Appetite and sleep seemed to be affected first, followed by changes in adjustment, orientation, and behavior.

It was felt that a maintenance dose of 6 grains daily is necessary to maintain the achieved results, since patients on a smaller dosage tended to regress in a few weeks.

In view of the generally unsatisfactory results

of almost any form of treatment in this class of patients, the results obtained by the author indicate that oral Metrazol therapy seems to have a definite place in the treatment of cerebral arteriosclerosis in aged patients and is well worth trying.

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## SINUSITIS AND BRONCHIECTASIS

The relationship of sinusitis to bronchiectasis is a controversial subject. There are those who feel that chronic sinus infection produces the conditions that lead to bronchiectasis. Others contend that sinusitis accompanies bronchiectasis, and the same causative factor applies to both. It is said that this causative factor may be allergy, especially sensitivity to bacteria. There are many instances of bronchiectasis, where sinus infection cannot be demonstrated, and certainly sinusitis is not necessarily accompanied by bronchiectasis. Frequently, however, proper treat-

ment of the sinuses will help alleviate some of the discomforting symptoms of bronchiectasis, and this should be undertaken if it can be done conservatively. It follows, too, that if there is bacterial allergy in the presence of purulent sinusitis, the latter may be the source of the infection, and its treatment may help bronchiectasis. We must consider also that purulent exudate that is aspired may produce bronchial obstruction which, when it exists for some time, may be the causative factor in bronchiectasis. *Arthur J. Cracovaner, M.D. The Nose and Throat in Relation to Pulmonary Disease. New York J. Med. June 1, 1954.*

## CASE REPORTS



# Respiratory Symptom from Sulfathiazole in Agranulocytic Agina

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When it became reasonably clear, in the case reported here, that a staphylococcic infection, rather than sulfathiazole used in the early treatment, had caused agranulocytosis, the drug was again administered, with both favorable and toxic effects. Polymorphonuclear cells promptly reappeared in the peripheral blood stream after having been absent for six days; and a toxic reaction of the drug was observed in a rapid, sustained rise of respiratory rate. A careful search of the literature failed to reveal any report in which increased respiratory rate was noted as a toxic manifestation of sulfathiazole.

The patient, a girl 5 years of age, weighing 45 pounds, was first seen at her home because of a complaint of sore throat and fever. Six weeks before the present illness began the child had nasopharyngitis and pyelitis, in the treatment of which she had an allergic reaction to penicillin but responded promptly to sulfathiazole. There were no other pertinent items either in the child's or in the family's history. The

first examination in this illness revealed only nasopharyngitis. Bed rest, increased fluids intake and aspirin were prescribed. Fever continued rather higher than is usual in uncomplicated nasopharyngitis and on the third day of illness 2.5 gm. of sulfathiazole daily in divided doses was prescribed. On the third day of this medication the temperature returned to normal and the drug was stopped. Throughout the ensuing two days the temperature remained normal and, except for occasional complaint of soreness of the tongue and throat, the child felt well and was happy. Then, suddenly, the temperature rose to 105 F. and the child looked and acted seriously sick. She was admitted to the hospital the same day.

*Course in Hospital.* — On admission all positive observations of the physical examination were limited to the tongue, pharynx and ears. A thin, grayish membrane hung loosely from the pharyngeal walls and soft palate. The tongue was heavily coated, and an ulcer, approximately 1 cm. in width, was present on the right border anteriorly. The left tympanum was red but not bulging and a small amount of sero-sanguinous

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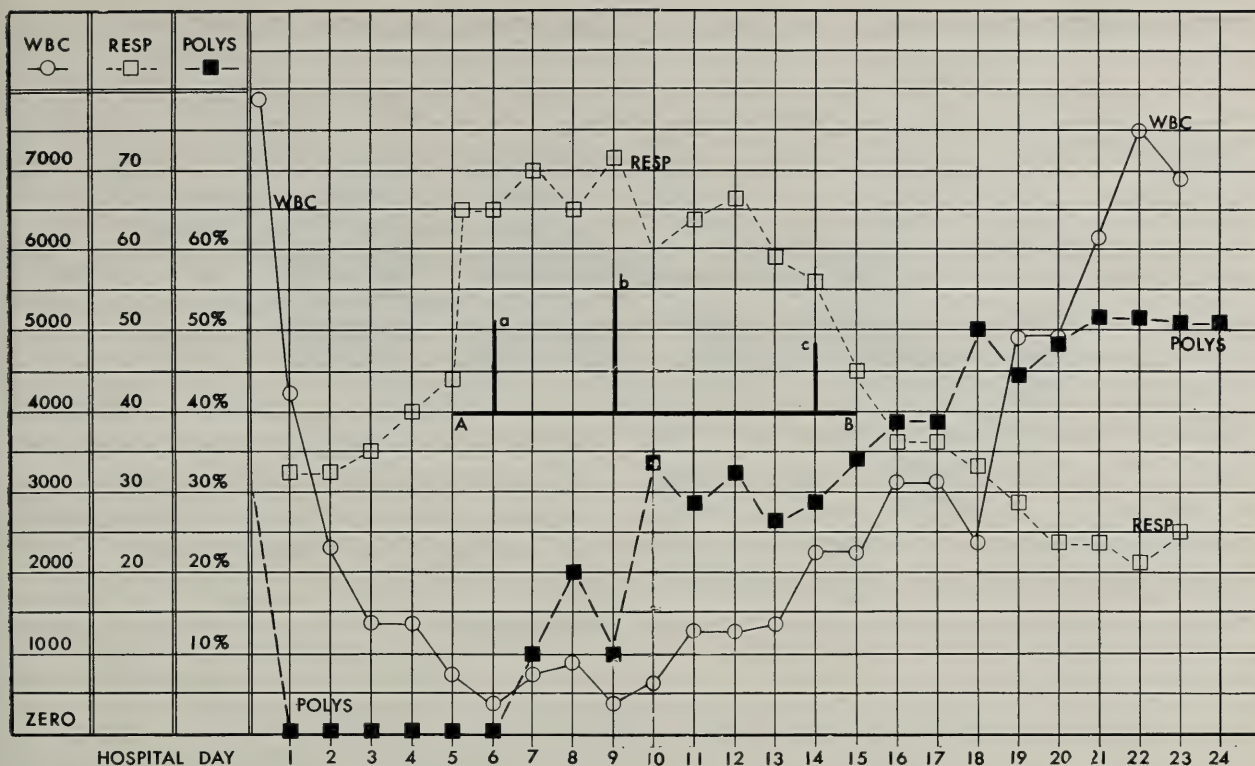


Figure 1. Close correlation of respiratory rate with the blood level of sulfathiazole (a, 5.7, b, 7.4, and c, 3.6 mg. per hundred cubic centimeters) is shown during the period, A to B, of chemotherapy. A favorable change in the polymorphonuclears and in the total white blood count is apparent during chemotherapy.

material had perforated through the right tympanum. The temperature was 104.6 F., respirations 32, and the blood count showed 2,800,000 erythrocytes; 4,200 leucocytes with 29 per cent. polymorphonuclears, 69 per cent. lymphocytes, and 2 per cent. eosinophiles. A transfusion of 250 cc. of whole blood was given. On the second day when the leucocyte count fell to 2,300, with no granulocytes, a diagnosis of agranulocytic angina was justified.

Daily blood transfusions did not arrest the fall of leucocytes, which, on the fifth hospital day were 800, and on the sixth day 480, with no polymorphonuclears. During this period the temperature curve was distinctly septic, ranging between 99 and 106.2 F. The child became extremely pale, drowsy and unresponsive. Culture of the sero-sanguinous material from the draining ear showed staphylococcus aureus and non-hemolytic streptococcus; a throat culture revealed predominant colonies of staphylococcus aureus; and successive blood cultures showed no growth.

Although it had been assumed that agranulocytosis had occurred in this case as a toxic reaction of sulfathiazole, doubt of such pathogenesis now seemed reasonable. The drug had not been used in the preceding eight days; sepsis

was apparent in the continuing wide sweep of temperature; and the blood picture continued to be worse each day. Because prompt clinical improvement followed the use of sulfathiazole in the earlier stage of the disease a further trial of the drug was decided upon. An initial dose of 2 gm. was followed with 1 gm. every four hours. Respirations which were 44 per minute at the time the first dose was given were 65 four hours later, an acceleration of approximately 50 per cent. The increased rate of respirations was maintained in direct proportion to the blood level of sulfathiazole throughout the remaining days of administration of the drug. (Figure 1.) At this time and throughout the entire illness the chest was clear clinically and roentgenologically. Thirty-six hours after use of the drug was resumed the leucocytes had risen to 800 with 10 per cent. polymorphonuclears. This was the first time in six days that granulocytes were found in the peripheral blood stream. The following day the count rose to 950 leucocytes with 20 per cent. Polymorpho-nuclears and improvement continued almost daily until the child was discharged on the twenty-third hospital day with a total leucocyte count of 6,500 and 51 per cent. polymorphonuclears, and an erythrocyte count of 3,950,-

000 and hemoglobin content of 12.2 gm.

#### COMMENT

Agranulocytosis arising in the course of an infection in which sulfathiazole has been used presents not only a problem of cause, but one of further treatment as well. Contrary to current general opinion that the drug should be stopped completely in all such cases, evidence in this case suggests that if, during a period of withholding sulfathiazole, infection rather than the drug appears to be the granulopoietic depressant, further trial of the drug may be less dangerous than is now generally thought. Infection appears to have been the etiologic factor here because the leucocyte count, which continued to

fall during the period of eight days of withholding the drug, turned upward within thirty six hours after the drug was again administered and granulocytes reappeared in the peripheral blood stream. Presumably, the favorable change was indirectly brought about by the action of the drug in controlling the infection.

The rapid acceleration of respiratory rate on renewing chemotherapy is assumed to be a toxic manifestation of the drug because of its close correlation with the blood level of sulfathiazole, a correlation that was maintained even though the blood levels of the drug were within desirable therapeutic limits, and because the increased rate continued, despite marked clinical improvement, as long as the drug was given.

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### STRIKE IT RICH

For a long time many members of the medical profession have questioned the heartbreak stories of some participants appearing in the nationwide "Strike It Rich" television show. Many times the viewing audience, running into millions, has been left with the impression that financial assistance was needed in paying for the high cost of medical care. Last week AMA Public Relations Director, Leo Brown, and Executive Secretary, Robert Potter, Medical Society of the County of New York, called on Walter Framer, producer of the show. In a memo to me, Mr. Brown said "We were most impressed with the sincerity of Mr. Framer in his desire to assist the medical profession in any way possible. He apparently has great admiration for the medical profession and in no way wished to discredit the profession on his show."

Later he asked the AMA to check two cases. An appeal was made on behalf of one participant on the basis that repeated illnesses had accumulated a total medical bill of around \$6,000. On investigation, it was found that the family was covered by Blue Cross and had used this service on many occasions. A call to the doctor revealed

that a frank discussion of fees had taken place and the parents were perfectly willing to assume the responsibility of paying for the medical care involved. Additional information was received through social service workers and various hospitals to the effect that at no time had the patient been without medical care for financial reasons.

The second case involved a boy of 16 who had been blind since birth. He requested the privilege of appearing on the program in order that he might be able to obtain sufficient funds to pay for comprehensive examination of his infirmity. Our investigation revealed that the child had repeated examinations by the chief of ophthalmology at one of the medical colleges and had, for a number of years, been attending a state school for the blind.

In both cases, our investigations revealed that the individual had been adequately taken care of at the community and state level and consequently there was little basis for the appeal. This information was made available to Mr. Framer and both cases were considered ineligible to participate on his program. *Checkup On "Strike It Rich" Participants. Pennsylvania M.J. July 1954.*

# CASE RECORDS OF THE COOK COUNTY HOSPITAL

KARL MEYER, LEO M. ZIMMERMAN, DEPT. EDITORS

## Afibrinogenemia in Pregnancy

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Hemorrhage resulting from afibrinogenemia in pregnancy has been reported associated with premature separation of the placenta,<sup>17</sup> long-standing fetal death in utero,<sup>7,10,14</sup> and postpartum hemorrhage.

Recently we have seen a patient in whom the manifestations of afibrinogenemia were associated with pregnancy and a retained non-viable fetus. Diagnosis was relatively simple. Prompt therapy effected an excellent clinical course.

B. D., a negro woman, aged 30, had last menstruated during August, 1952, and her course was followed in the Obstetrical Clinic. She had five children and had been pregnant eight times. She was seen on May 7, 1953 when she showed no abnormal manifestations. Regular fetal heart tones were heard. On May 12 and 13 she experienced some palpitation, dizziness and headaches; on the evening of May 13th she experienced severe abdominal pains, vomited and noted cessation of fetal activity.

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The patient visited the Obstetrical Clinic the following day because of severe gingival bleeding of traumatic origin from the left upper molar area. While waiting to be examined in the Clinic she suddenly developed mild painless vaginal bleeding. Neither this blood nor a specimen removed by venous puncture clotted. Fetal heart tones were found to be absent. Urinalysis, which had previously been essentially negative now showed 2 plus albuminuria and an occasional red blood cell.

The patient was immediately admitted to the hospital. Previous pregnancies and deliveries in 1939 and 1940 had been normal but were followed in 1946 after 7 months' gestation by a premature delivery of a 3 pound infant, and a spontaneous abortion in 1947 after 3 months' gestation. Normal deliveries of term infants in 1949 and 1950 followed. During her last pregnancy prior to this admission the patient reported a 2 pound 4 ounce stillbirth in June, 1952, which had been preceded by several weeks of vaginal bleeding. During this period she had been given two transfusions and had noted vaginal bleeding associated with prolonged standing in the first postpartum month.

On examination in the hospital the blood pressure was 140 systolic, 90 diastolic; pulse 92; respiration 24 per minute. The patient was in no apparent distress. Petechiae were present in the conjunctiva and there was moderate bleeding from the left upper molar area, although there was no evidence of a traumatic lesion. There was a grade 2 soft systolic murmur over the entire precordium. The uterus was that of an 8 months pregnancy and was noted to be tense and tender to palpation; no fetal heart tones were present, and there was vaginal bleeding. A specimen of venous blood was obtained, which failed to clot after several hours.

A sterile vaginal examination confirmed the observations made and revealed the fetus to be at a minus one station in a cephalic position. There were no uterine contractions.

The membranes were ruptured and an intravenous drip was begun of 1000 cc. 5 per cent glucose in water containing 10 minims of pitocin. The patient continued to bleed moderately from the gingival and vaginal areas. About 2½ hours later a non-macerated stillborn was delivered on May 14, 1953. The patient lost an additional estimated 500 cc. of blood during delivery. A normal placenta was expressed and the perineum remained intact. Ergotrate and whole blood were administered, because the patient continued to bleed from the gingiva and uterus.

During the next few hours several transfusions and other fluids maintained the patient's blood pressure at approximately 110/80, although it dropped below a systolic of 100 for a short period. Four hours after delivery bleeding ceased from both areas mentioned, and no further hemorrhage occurred during the hospital stay.

The blood obtained three hours prior to delivery did not clot after 12 hours and fibrinogen was not demonstrable in this specimen. Blood drawn on May 14, the morning following delivery, revealed: red blood cells 2,090,000; hemoglobin 40 per cent; (6.2 Gm.); white blood cells 11,600; platelets 60,610, and a reticulocyte count of 2.5 per cent.

The clotting time was 6 minutes; the bleeding time 20 minutes; and the prothrombin time normal. The following day, after another 1000 cc. transfusion of blood, the hemogram showed: red blood cells 2,930,000; hemoglobin 53 per

cent (8.2 Gm.); white blood cells 9,500 (74 polymorphonuclear cells; 2 bands; 3 eosinophils; 17 lymphocytes, and 4 monocytes), platelets 263,000 and a reticulocyte count of 3.3 per cent. Examination of the marrow showed it to be hypercellular; the megakaryocytes were slightly increased in number, and the RBC:WBC ratio was 2:3. Erythropoiesis was normoblastic and granulopoiesis was intact. There was a slight increase in reticulum and plasma cells. These observations were interpreted as those of accelerated erythropoiesis due to the pregnancy and blood loss.

There was no further hemorrhage. The patient was discharged on her fourth hospital day. She has been seen at intervals in the Clinic and has continued well except for one episode of thrombophlebitis 3 weeks postpartum, which occurred in the leg where fluids were administered.

## DISCUSSION

The fibrinolytic enzyme, profibrinolysin, is postulated to exist normally in plasma in an inactive form.<sup>6,16</sup> This is the proenzyme precursor of fibrinolysin. The formation of fibrinolysin from profibrinolysin is regulated by two factors of opposing activity known as fibrinolysokinase and antifibrinolysokinase. This hemostatic mechanism can be altered to activate fibrinolysokinase which converts profibrinolysin to fibrinolysin by kinases liberated through tissue injury<sup>16</sup>.

It has been shown that hemorrhage from premature placental separation, retained non-viable fetus, surgery, burns, shock, hemorrhage, transfusion reaction, parenchymatous liver impairment, pulmonary surgery, disseminated carcinoma, metastatic carcinoma of the prostate, and tuberculous infection<sup>1,2,8,14,15,16,19</sup> may produce a fibrinolysin resulting in severe bleeding. This fibrinolysin is in turn inhibited by antifibrinolysin which is influenced by ACTH, cortisone and possibly two splenic factors.<sup>16,18</sup> Bleeding manifestations associated with fibrinolytic purpura are usually due to alteration of several of the factors involved in blood coagulation, but the fundamental resulting defect is hypofibrinogenemia or afibrinogenemia.<sup>4,16</sup>

There are four theories currently advanced for the explanation of this phenomenon:

1. *Intravenous Clotting*.—Amniotic fluid behaves as thromboplastin in oxalated plasma and

can be substituted for commercial thromboplastin in the one stage prothrombin test.<sup>9</sup> According to this theory, in premature placental separation, amniotic fluid is infused into the blood stream where it elicits clotting by virtue of its thromboplastic properties.<sup>11</sup> The clotting occurs to such an extent that fibrinogen is rapidly depleted below 100 milligrams per cent, the critical level required for clotting;<sup>13</sup> massive uterine hemorrhage may then occur. In cases in which a non-viable fetus is retained, it has been postulated that the autolyzed products of conception, such as placenta, and especially decidua, which is rich in thromboplastic activity, elicit intravenous clotting through a similar mechanism by releasing thromboplastic substances.<sup>9</sup>

**2 Proteolytic Activity.**—Fibrinogen may be reduced by proteolytic activity. Bleeding manifestation of the fibrinolytic type would be due to enzymatic digestion of many of the blood proteins involved in coagulation.<sup>16</sup> Thus clotting defects associated with fibrinolytic activity may show, in addition to hypofibrinogenemia, other manifestations, such as thrombin inhibition, and thrombocytopenia.<sup>5,9</sup> Shock itself may be contributory, for a fibrinolytic enzyme has been demonstrated in shock and tissue destruction.<sup>9</sup>

**3. Certain Conditions Producing Anticoagulants.**—It has been demonstrated that injections of meconium from amniotic fluid in experimental animals produces a prolonged clotting time, a decrease in platelets, shock, and the release of a powerful anticoagulant which is unaffected by protamine or toluidine blue. Thus, this anticoagulant is believed to exert its influence by preventing the formation of fibrin from fibrinogen.<sup>12</sup>

Alpha and beta globulins may also behave as anticoagulants to inhibit the conversion of fibrinogen into fibrin.<sup>15</sup>

Similarly it is postulated that an antigen-antibody reaction between placenta and maternal serum may result in the formation of such an anticoagulant.<sup>7</sup>

**4. Rate Reduction of Fibrinogen Synthesis.**—The rate of fibrinogen synthesis may be decreased. There is the possibility that the reticulo-endothelial system is affected in such a manner that fibrinogen synthesis is impaired.<sup>2,7</sup> This is unlikely however, in the presence of a normally functioning liver.

The case reported is believed to be most ade-

quately explained on the basis of fibrinogen destruction by proteolytic activity. This would also account for the greatly reduced number of platelets, for the abnormal proteolytic activity may affect platelets as well as the various blood proteins essential to coagulation.<sup>16</sup> It is of interest to note, moreover, that the platelets contain 70 per cent as much antifibrinolysin as does plasma.<sup>3</sup>

The major concern in this case is centered about the differential diagnosis and subsequent therapy. The presence of petechiae and persistent hemorrhage from the gingiva as well as the uterus was helpful in making the clinical diagnosis. Prompt consideration of afibrinogenemia in such instances of uterine bleeding associated with pregnancy is essential as this diagnosis can be easily ascertained by simple bedside methods.

The most practical test, as was applied initially in this case, is the clotting time. If a clot forms normally, it is allowed to remain in the tube at 37° C. for several hours, with frequent observation for evidence of lysis, manifested by dissolution of the formed clot with its return to a fluid state. Either the inability of the clot to form initially, as in this case, or the subsequent dissolution of the clot implies that a reduced amount of fibrinogen is present or that proteolytic action is producing an afibrinogenemia manifested as an abnormal bleeding tendency.<sup>17</sup> The bleeding time is of significance here only if prolonged. A more quantitative estimate of fibrinolysis can be obtained at the bedside also, by a simple method of diluting the blood sample serially in Ringer's solution and observing the dilution at which lysis occurs.<sup>13</sup> If laboratory methods are available, fibrinogen determinations can be obtained; but the levels will depend on the amount of fibrinogen destroyed when the blood is tested. It is pointed out, however, that for practical reasons, either the clot observation or the technique of dilution in Ringer's solution is most useful for early diagnosis.

When the clotting time is normal and the clot remains stable, a platelet count as well as observation of the clot for retraction will provide information required in considering thrombocytopenia as the primary etiologic factor in such a case. It is noted that in this case the platelet count was reduced, as may often occur in cases of afibrinogenemia due to destruction of more

than a single element required in coagulation.<sup>16</sup>

It is important that afibrinogenemia be considered early in cases of uterine bleeding associated with pregnancy. Prompt specific therapy may be life-saving. Preventing or combating shock is important. Shock alone in certain circumstances may elicit fibrinolysis.<sup>12,16</sup> In this case blood and other fluids were used for this purpose. Blood also aids in replacing fibrinogen, and in some centers, Cohn's Fraction I, containing a high concentration of fibrinogen, is also available. Commercially prepared fibrinogen should become more generally available, and an emergency supply kept in each hospital, or at least in convenient centers.

The clot observation test can also be used advantageously in determining the fibrinogen level obtained during therapy. Following the elimination of shock and return of an adequate blood coagulation mechanism by blood and fibrinogen (Fraction I) administration, delivery of the fetus by section, or as in this case, by induction, can be accomplished with greater safety. It is important to remove the fetus as soon as feasible. Removal will often allow the fibrinogen level to return promptly to normal levels.<sup>7</sup>

#### SUMMARY

A case of uterine and gingival bleeding due to afibrinogenemia in a pregnant negro female has been presented. The mechanism in this case was assumed to be that of fibrinogen destruction from proteolytic activity. Of interest in the patient reported was the presence of thrombopenia, also explained by a proteolytic process. We have emphasized the simple, practical means of diagnosis, so that prompt specific therapy may be instituted early. The patient survived and had no further manifestations of afibrinogenemia.

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# EDITORIALS



## THE COLLAGEN DISEASES

The collagen diseases have been in the limelight during the past decade. These conditions include disseminated lupus erythematosus, scleroderma, dermatomyositis, periarteritis nodosa, rheumatoid arthritis, and rheumatic fever. This group of diseases involves principally the connective tissue and they have many features in common. The basic lesion is fibrinoid degeneration of collagen, the protein constituent of the connective tissue. Diminution or occlusion of the vascular lumen occurs when the pathologic reaction is intense; ischemia of soft tissue and atrophy of bone may ensue.

Fever occurs in all the collagen diseases. The next most common manifestations are skin eruptions, arthralgia, and heart involvement. Renal, vascular, and serous membrane changes are not unusual. Symptomatology may be clear-cut atypical or absent. As a rule there are so many overlapping symptoms that diagnosis usually hinges upon the results of laboratory tests.

Disseminated lupus erythematosus comes to mind whenever the typical butterfly eruption is noted on the face. If this lesion is absent, but the malady is suspected, biopsy or a careful search of the blood or bone marrow for LA cells becomes necessary. Scleroderma is easy to recognize because most of the findings are confined to the skin; biopsy rarely is needed. Der-

matomyositis and periarteritis nodosa are likely to be more obscure. Diagnosis seldom is possible without the aid of skin or muscle biopsy.

Students were taught 25 years ago to look for nodules along the vessels of the lower extremities to diagnose periarteritis nodosa. We now know these lesions are unusual. Furthermore, the abdominal vessels are involved more frequently than are the peripheral vessels. The most characteristic feature of the illness is its bizarre nature.

The pattern of rheumatic fever and rheumatoid arthritis is so well known, these maladies seldom are missed except in mild or atypical cases. The white blood count, sedimentation rate, X-ray, and electrocardiogram are used in diagnosis and in following the course of rheumatic fever.

The relationship between collagen diseases and the hypophysial-adrenal system is not clearly understood but ACTH and cortisone have a favorable affect upon the clinical course of these conditions.

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## RAPID PROGRESS

The following report should answer those who argue that organized medicine limits medical school enrollment and is intent on keeping down the supply of physicians:

"1. A record ratio of one doctor for every 730 persons in the United States was reached during

1953-54. This is the highest proportion of any country but Israel.

"2. The record graduation of 6,861 doctors during 1953-54 brings the number of doctors to approximately 220,100.

"3. The enrollment of 28,227 undergraduate medical students is the highest in the history of this country and the freshman class enrollment of 7,449 also sets a record.

"4. Volunteer teaching without pay was done by 21,328 physicians to aid in educating medical students.

"5. Within the next five to six years there should be ten new four-year schools."

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### **JOSEPH S. LUNDHOLM, M.D. 1891—1954**

Joseph S. Lundholm, M.D., Councilor for the First District in the Illinois State Medical Society for the past six years, died at his home in Rockford on Thursday afternoon, October 7, 1954. The cause of death was coronary occlusion.

Dr. Lundholm was born in Chicago, June 4, 1891. His parents moved to Rockford when he was a small child and he remained a citizen of that city until his death.

He was graduated from the University of Illinois College of Medicine in 1913. On completion of his internship, Dr. Lundholm located in Rockford, where he gradually built up an extensive surgical practice. He was also very active in numerous medical and surgical organizations during his lifetime. In addition to membership in his county and state medical societies and the American Medical Association, he was a Fellow of the American College of Surgeons, the International College of Surgeons, Industrial Medical Association, and the American Fracture Society. Dr. Lundholm presented many scientific papers before these, and other groups, and presented papers on a South American tour a short time ago.

Being interested in music, Dr. Lundholm sang with the Chicago Swedish Glee Club and he organized and directed the "Singing Doctors" octet in Rockford.

Only one month before his death, Dr. Lundholm completed and moved into the Lundholm Surgical Group Building, occupied by himself and three associates.

He was married in 1916 to Lillian Lutzhoff.

He and Mrs. Lundholm traveled widely, their trips covering most of the world. In addition to his widow, other survivors are a daughter, Mrs. A. Campbell Perks, and three grandchildren, all of Rockford; a brother Stanley, a sister, Mrs. Raymond Diettrick, and his step-mother, Mrs. Hilma Lundholm of El Paso, Texas.

Dr. Lundholm was a regular attendant at the annual meetings of his State Medical Society, and he served one year as its first vice-president. He attended the Council meetings regularly, and cared for the problems of his large district throughout the six years he was active as their Councilor.

The Council and Officers of the Illinois State Medical Society, and the thousands of medical men who knew Joe Lundholm, unite in sending their expression of sympathy to Mrs. Lundholm and her family, in the memory of one who invariably believed in and lived according to the Golden Rule.

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### **NEW SELECTIVE SERVICE ANNOUNCEMENT FOR PHYSICIANS**

Major General Lewis B. Hershey, Director of Selective Service, has announced that all physicians, dentists and veterinarians who are nationals of Germany must register with Selective Service if they have been admitted to the United States for permanent residence. Even though they have not declared their intention of becoming citizens and might have previously been exempt from registration under the so-called "Doctor and Dentist Draft Act," they are now required to register, Hershey emphasized.

In the Proclamation (No. 2915), issued December 27, 1950, the President exempted from special registration under the so-called "Doctor and Dentist Draft Law" aliens who were residing in the United States, who had not declared their intention of becoming citizens and who were nationals of any country with which there was in effect a treaty or international agreement exempting its nationals from military service while they are within the United States. Germany was one of the 18 countries with whom we had such a treaty, General Hershey pointed out, so German doctors were not formerly required to register. That provision of the treaty with Germany relating to the reciprocal exemption from mili-

tary service expired on June 2, 1954, General Hershey explained, so those doctors who had not yet reached their 50th birthday on January 15, 1951 must now present themselves to a local board and register as special registrants.

We still have treaties or International agreements with 17 countries which contain provisions for the reciprocal exemption from military service of each other's nationals while they are within the other's country. The countries are:

Argentina	Honduras	Paraguay
Austria	Ireland	Siam
Costa Rica	Italy	Spain
China	Latvia	Switzerland
El Salvador	Liberia	Yugoslavia
Estonia	Norway	

No estimate was available as to the number of German doctors who may become liable for service in our armed forces as a result of expiration of the treaty provisions.

**THE HOST-PARASITE-SOIL  
RELATIONSHIP**

**An Enlarging Concept  
(An Historical Approach)**

**David J. Davis, M.D.**  
**Permanent Historian**  
**Illinois State Medical Society**

Man will never cease to wonder about the origin (as well as the destiny) of both himself and his parasites.

Human and parasitic associations in one way or another are continuous and inseparable. Each may be harmful, helpful or indifferent to the others. The nature of these relationships are, in general, competitive. The resulting contests are frequent and on a grand scale. The stakes are highlife or death!

Every physician in the State of Illinois, as in all other States for that matter, is reminded in his daily work of the principle known as the host-parasite relationship. For, in spite of modern revelations of medical science, a large proportion of our diseases are still parasitic.

We use the term "parasite" here in its broadest sense, to include viruses, bacteria, moulds, protozoa, insects, worms, arthropods, and some other forms whose identity is still obscure or whose relations are remote or undetermined.

For the past century or more, a large fraction

of medical research on infectious diseases has been concerned with this host-parasite relationship. The results, on the whole, have been most gratifying, for during this period it has been conservatively estimated that approximately 75% of the transmissible diseases in this country have been eradicated. Both preventive and curative measures have been applied in various and complex ways to bring about these extraordinary results.

Authorities seem fairly well agreed that early man evolved somewhere on the largest land-mass, namely, the Triple Continent (Asia, Europe, Africa) a million years ago more or less. Parasitism had, no doubt, been well established in the very large number of both plants and animals that existed there before man arrived. Probably some of these parasites were even then potentially pathogenic for him. It would seem reasonable to assume therefore that the human species as it evolved was a "carrier" of certain infectious agents from its very inception. Furthermore, it probably has continued to carry these or similar agents of disease down through the later millennia and even to the present time.

This host-parasite relationship is an ancient biological phenomenon, the beginnings of which we may assume were the first efforts made by primitive organisms to obtain food and other life necessities. As organisms do today, they then used their associates, living and dead, as a source of food and protection. For their purpose they took advantage of useful environmental factors on or in the coexisting forms. On the surface of the larger forms was an abundance of organic food material which they could easily utilize. And within their orifices, channels and tubes, was an even more abundant supply of their necessities.

But it was not always a one-sided relationship, being often a very definite give and take transaction from the beginning. In some instances the minutest organisms, because of adaptive and reproductive powers, were able to gain a more or less permanent foothold and thus could be carried about by an associate, usually a larger form, and thus establish this coexisting relationship. This parasite, that is, the smaller or apparently weaker of the two, might then at times become the dominant organism and control the final or ultimate outcome; as, for example,

when the parasites or germs in a fatal infection exhibit their powers by reproduction or by generation of toxins in such a way as to cause death of its larger associate.

The host-parasite relationship is sometimes a simple system, or again an extremely intricate and complex one. From the practical point of view the system in reality may be considered a series of links in a chain, long or short, along which are many vulnerable points of attack. Some of these points concern the host, primarily, other the parasite.

The attacking agents as devised by man are manifold and diversified. They include, broadly, many cleansing agents, soaps, powders, medicated ointments, internal and external antiseptics, anthelmintics, specifics such as quinine, mercury, arsenic, and sulphur drugs; also biological products such as that of the toxin antitoxin principle. And even more intriguing than any yet observed are the newer agents we now call antibiotics.

An enlarging concept based on accumulating evidence indicates that as these various organisms live together, their specific products interact so that their lives become an intricate complex of "coactions." Some of these coactions are mutually advantageous while others are antagonistic or destructive to each other. Again, their relationship may be one of indifference, being neither positive nor negative. These "coactions" proceed constantly on a relatively huge scale.

While we still use the term "biological", the more the details of these coactions are analysed, the more clearly they are seen to be chemical or physiochemical in nature. It is from these intricate studies that a great number of problems now are pressing perpetually for solution. To one special group of these coreactors which reveal antagonistic relations, the antibiotics above mentioned have come into common use. Not only has this word a theoretical significance but an increasingly practical one, as indicated by the enlarging list of these therapeutic agents appearing almost from day to day. They are rapidly coming to dominate both practical medicine and pharmacy. They include such products as gramicidin, tyrocidine, penicillin, actinomycin, streptomycin and many others too numerous to mention here.

Still more intriguing is the fact that it is in the soil where the principal agents responsible

for these complexities of "coreactions" are found. The evidence is such that, as never before, the science of the soil, namely agriculture, has again revealed, as it did long ago in the matter of foods, its intimate relationship to the problems of health and disease.

Long ago, too, we recognized the good earth as the most universal sanitary agent known. Now, in a still more astonishing way, we are discovering that the soil is the potential source of some of the most effective curative and therapeutic agents known to man.

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## **VOLUME II "HISTORY OF MEDICAL PRACTICE IN ILLINOIS 1850-1900"**

The manuscript for the second volume of the History of Medical Practice in Illinois is now complete. The Committee on Medical History has been working for several years to get this material and arrange it properly for publication. The Committee has recently awarded the contract for its publication, and it will soon go to press.

It is hoped that the completed book will be available for delivery by the end of this year. The Illinois State Medical Society and its Committee on Medical History are quite anxious to receive many prepublication orders before the book comes off the press as the advance orders will aid materially in determining the number of books to be published. Orders have been coming in from physicians, various organizations and from a number of people outside of the medical profession.

We are publishing elsewhere in this issue of the Journal an order form which may be signed, detached and mailed to the Secretary for the ever increasing list of subscribers. Why not order several copies for distribution as Christmas presents?

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## **FIRE HAZARDS IN NURSING HOMES**

The National Board of Fire Underwriters recently published a new edition of its "Suggested Ordinance of Nursing, Convalescent and Old Age Homes", bringing up to date the suggested ordinance first published by the National Board in 1945. This proposed ordinance is recommended for adoption by municipalities, and may be of use in developing state and county regulations.

During the past 10 years tragic fires in nursing and old age homes took the lives of 88

persons. According to the National Board, the record shows the loss of life resulted from several causes. Chief among these causes, the use of combustible fibreboard on interior walls and ceilings, unenclosed stairs and dumb waiters, lack of sufficient exits, inadequate separation for parts of building containing special fire hazards, and lack of automatic sprinkler protection.

Although the proposed 1945 ordinance was approved by a number of cities and a number of states have adopted regulations providing for fire safety in nursing, convalescent and old age homes, serious fires have continued to occur with an increased toll of lives. Although some of these homes have modern buildings of fire proof construction, too many are still in buildings of combustible construction. In many instances large, old residences are utilized for nursing homes, one principal factor apparently, the larger number of people who can receive care in that type of home.

Many of those receiving care in these homes are elderly, and many are so completely disabled, that they could not make a quick exit under their own power in case of fire. Frequently these people are housed on a third floor of a large, old home, with only one stairway, and too often this a narrow one. This naturally greatly increases the fire hazards. In Illinois nursing homes are licensed by the State Department of Public Health, and fire hazards checked by the personnel from the State Fire Marshall's office.

Anyone interested in receiving a copy of the "Suggested Ordinance on Nursing, Convalescent and Old Age Homes", may receive one by writing to the Engineering Department, National Board of Fire Underwriters, 85 John Street, New York 38, New York.

Physicians everywhere should recommend to their city and county officials that copies of this proposed ordinance be received and that they make efforts to greatly reduce the fire hazards in nursing homes in their respective communities.

## DEATHS FROM ACCIDENTAL FALLS

Statisticians of the Metropolitan Life Insurance Company in a recent release, stated that accidental falls take about 21,000 lives each year in the United States, this approximately as many as are taken by tuberculosis. As a cause of accidental death, falls rank second to those caused by automobiles. About two thirds of these deaths following falls, occur in and about the home.

Under the age of 75, more accidental death from falls occur in males than in females, and above that age the reverse is true. More than half of the deaths from falls occur in people 75 or over. It is interesting to note the nature of falls at various ages. Below the age of 15, falls from windows, porches, swings, trees and fences are the most common types. Swimming accidents, and principally from diving, causes many of the deaths of boys in their late teens. In the 25—44 age group, falls on stairs cause nearly a fourth of the fatalities, and about one third in those between 45 and 74 years of age. Among the older people, a large proportion of the fatal falls occur while they are walking about in the house.

Safety education is a prominent factor in the effort to reduce the fatal accidents from falls. Safety measures in the home especially for the older groups, include handrails on stairs, adequate illumination about the house, anchoring rugs and keeping stairs and hardwood floors clean and dry. Nearly every physician has seen accidents resulting from falls in bathtubs, on stairs, and from stumbling over many loose articles on floors. Physicians everywhere should aid in every way possible, the dissemination of information to reduce this type of accidental injury, and should issue warnings to their elderly patients, among whom the fatalities from accidents take the greatest toll.

# MEDICAL ECONOMICS

**The Medical Economics Committee. John R. Wolff, Chairman, Walter C. Bornemeier, Edward W. Cannady, Roland R. Cross, Jr., E. F. Dietrich, W. W. Fullerton, Edwin F. Hirsch, Frederic T. Jung, W. R. Malony, Caesar Portes, William Requarth, Frederick W. Slobe.**



## Nursing Education

**Roland R. Cross, Jr.  
Chicago**

It is an old, old saying that one does not like to fight on more than one front at once. And yet, one must defend one's principles in areas where attacked. Medicine has had several fronts of attack in the past few years. There has been the threat of socialized medicine. There has been disharmony on the subject of fee-splitting. There have been the ever-enlarging hospital and medical insurance plans, most of which were not looked upon with favor fifteen or twenty years ago. There has been the question of medical care to the non-service-connected ill veteran. In the welter of things, one problem of major concern has been to some extent by-passed by physicians. Now, it has become very important. This is the change in the status and concept of nursing education. Major changes have occurred and are still taking place. They are definite factors in producing increased costs of illness to the patient. Physicians are considered by the public to be the leaders in the field of medicine. Anything that causes increased cost of medical care to the public is blamed on doctors.

Dr. Joseph T. O'Neill from Ottawa, reporting as councilor from the second district to the House of Delegates of the Illinois State Medical Society

on May 18, 1954, said, "Your councilor should like to call the attention of the House of Delegates to the fact that the small schools of nursing are apparently slowly, but surely, being squeezed out of the medical picture. In the large and very populated second district, serving approximately 200,000 persons, only one hospital still maintains a nursing school. Current factors, however, indicate that this particular hospital is eminently near, if not in actual danger, of having to close its school of nursing.

"Why? The hospital is willing to maintain its school of nursing; its economic attraction is satisfactory and sound. The stringent regulations and particular philosophy of the new concept on nurses' training set up by the accrediting boards appear to be the restraint. Thus, two obstacles occur. Not only is the recruitment of young women to the nursing profession to serve this community impeded, but the employment of suitable personnel from outside the community, namely, graduates of the larger schools of nursing, is blocked. In addition, the lack of extensive cultural facilities ordinarily found in the small community looms high as an obstacle to those who might be drawn from a metropolitan area.

"It is the opinion of your councilor that too many small schools of nursing have been closed in Illinois. Surely there is some place left for the small school in the rapidly advancing progress of medicine and its allied art—nursing. Has not the small school throughout the years done valiant work to educate and keep in its community its own graduates? Is it not true that the small school of nursing has made valuable contributions to medicine and to the care of the sick? These graduates should not be forgotten nor should those who would follow in their footsteps.

"Your councilor believes that we must pause and consider. It may be later than we think. Once the small school of nursing with its potential contribution is gone, the problem to reactivate will be difficult."

Dr. O'Neill has made a good point. We should pause and consider. What are some of the changes? Ten years has brought many changes in requirements set up by the accrediting bodies. Today, the education director is required to have a Master's Degree. A small school with approximately twenty-four students per class should have three full-time pre-clinical instructors, and two full-time clinical instructors; all five of them should have their Bachelor's Degree. Nurses who undergo the toil of acquiring this additional training expect to have increased compensation. Ten years ago, it was rare to find any nurse with a college or university degree; even the Director of Nurses rarely had a degree. Formerly, students worked an eight hour day for six days a week, and, in addition, had class hours. Now students work an eight hour day, five days a week, and this includes class hours. Ten years ago, students were given a two week vacation each year; now they get four weeks per year. Requirements in the way of increased library and visual aid materials have increased. It is estimated that a hospital now gets about thirty per cent as much work out of its students as compared to ten years ago. The idea used to be that a nurse learned by working under supervision. Now it is more than that; she is taught in a more formal manner and patients are used to demonstrate the teaching. All this is at the expense of the hospital and ultimately at the expense of the patient who is sick in the hospital. It is the rare institution which is so endowed that the cost of nursing education is not passed on to the

patient—just as hidden government taxes are ultimately paid by the small consumer. One hospital, accredited by the National League of Nursing Education, and with about twenty-five students per class, recently estimated that it cost the hospital \$90,000 per year to maintain its school.

Physicians should ask themselves—has all of this change in the past ten years improved the nursing care to the patient? Has it produced more or less nurses? Has it increased the burden of medical costs to the patient?

Let us think over the problem. No problem exists but what a little thought can aid in its solution. I think we must recognize that nursing students do not come in the main from backgrounds having money. Such young women go to colleges with sororities and half play and half study. Most nursing students, on the other hand, come from backgrounds which cannot afford such leisure. I do not think that we can hope to attract the former group away from college into nursing by trying to create a small college at each small hospital. By creating too much of an intellectual atmosphere, we will tend to drive away the girls who will make the good nurses. If the girl is basically book-minded, she will be inspired to acquire a true college education by working her way through college with the aid of scholarships. We must gear the appeal back to the girl who is willing to learn about how to nurse a sick patient—a patient who may be vomiting, or incontinent, or involuntary.

On the other hand, if what is truly needed is more full-time instructors and Masters and Bachelors degrees—and we must assume that within a few years it will be desirable to have Ph.D's—then we must think more in terms of how to meet the ever-increasing costs. We are, thus, more and more creating the small college. Would it not be better to rearrange the training program? We could have a cultural program at some college where all didactic work would be given. The girls would then go to the small hospitals in a sort of an intern-type of program to learn the bedside part of nursing. Thus, a college in Bloomington, Illinois, could have the girls for perhaps eighteen months, and they would do nothing at the hospital during this period. They would then go to the hospitals in

*(Continued on page 348)*

# CORRESPONDENCE



## CLINICS FOR CRIPPLED CHILDREN LISTED FOR DECEMBER

Seventeen clinics for Illinois' physically handicapped children have been scheduled for December by the University of Illinois Division of Services for Crippled Children. The Division will count 11 general clinics providing diagnostic orthopedic, pediatric, speech and hearing examination along with medical, social and nursing services. There will be 4 special clinics for children with rheumatic fever and 2 for cerebral palsied children.

Clinics are held by the Division in cooperation with local medical and health organizations, both public and private. Clinicians are selected among private physicians who are certified Board members. Any private physician may refer to or bring to a convenient clinic any child or children for whom he may want examination or may want to receive consultative services.

The December Clinics are:

December 1 — Hinsdale, Hinsdale Sanitarium

December 1 — Rock Island (Cerebral Palsy), Foss Home, 3808 — 8th Ave.

December 7 — Fairfield, Fairfield Memorial Hospital

December 8 — Alton, Alton Memorial Hospital

December 9 — Elmhurst (Rheumatic Fever), Memorial Hospital of DuPage County

December 9 — Springfield, St. John's Hospital

December 10 — Chicago Heights (Rheumatic Fever), St. James Hospital

December 14 — East St. Louis, Christian Welfare Hospital

December 14 — Effingham (Rheumatic Fever), St. Anthony's Memorial Hospital

December 14 — Peoria, St. Francis Children's Hospital

December 15 — Chicago Heights, St. James Hospital

December 15 — Springfield (Cerebral Palsy), Memorial Hospital

December 16 — Bloomington, St. Joseph's Hospital

December 16 — Rockford, St. Anthony's Hospital

December 17 — Chicago Heights (Rheumatic Fever), St. James Hospital

December 21 — Peoria, St. Francis Children's Hospital

December 22 — Elgin, Sherman Hospital

## OPERATION TODAY'S HEALTH

The Woman's Auxiliary to the Illinois State Medical Society has chosen as one of their major projects; to help the Physicians disseminate legitimate health information to the public by promoting sales and giving subscriptions of Today's Health.

As you know Today's health is "Organized Medicines" own publication of which we are all justly proud. We of the Woman's Auxiliary feel we can assist in spreading correct health information which has been approved by you Doctors; by making this magazine available to the public in all the key spots of the communities thruout the state where people have to wait and time to read.

This is just furthering the plan the Illinois State Medical Society has been using. At present you are sending over three hundred complimentary copies to the Governor and all state officials, members of the Illinois State Legislature, our two Senators, and all the Representatives from Illinois in Washington. You Doctors have made a wonderful foundation for us, may we not help carry on? If each of us does her bit, we can cover a large portion of the state, presenting to the public legitimate health information instead of the health propaganda published in so many other forms of print.

To make this "Operation" a success we have a four fold plan.

1—"Operation M.D. and D.D.S."—meaning a subscription of Today's Health in each physician's and Dentist's reception room available for their patients. You won't have to call us, we will call you. A committee will be at your November and December meetings with the subscription blanks, also they will try to attend the Conferences throughout the State during the year. Please greet them cordially with your dollar and a half. Could you get so much education any where for so small an amount?

2—"Operation Auxiliary" whereby we ask each member to send one gift subscription to her favorite spiritual advisor, school library, hospital reception room, bus station, Y.M. and Y.W.C.A.—M. and Y.W.H.A reading room, telephone operators rest room, beauty or barber shop, or any other key spot in her community where people have time to wait.

This at the cost of one dollar and a half to her.

3—"Operation Public". For the past year or so we are now permitted and encouraged to allow such groups such as Boy and Girl Scouts, Church Groups, Woman's Clubs, etc. to sell Today's Health for us. The Parent Teachers Organization has their own publication so does not want to take part. The County Medical Society must

give its approval thru the Auxiliary Today's Health chairman, before any grown up may make sales. The State Auxiliary has decided the organization making the sale may keep all the profits which are \$1.50 per subscription.

4—"Operation Christmas"—If we bind the three previous "Operations" into a united effort; by Christmas of '54 we can have a full scale program of legitimate health information available thruout the state and waiting to be read.

WHAT BETTER TIME TO GIVE THAN CHRISTMAS?

WHAT BETTER GIFT CAN YOU GIVE THAN EDUCATION?

WHAT EASIER WAY THAN GIVING TODAY'S HEALTH?

IS \$1.50 TOO MUCH TO PAY FOR TRUTH INSTEAD OF PROPAGANDA?

WILL YOU PLEASE DO YOUR SHARE?

Mrs. O. G. Schneidewind  
Chrm. Today's Health

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### **BOUND COPY OF BULLETIN ON RHEUMATIC DISEASES AVAILABLE TO PHYSICIANS**

The first four volumes of The Bulletin on Rheumatic Diseases have been bound in soft cover and are now available to physicians.

The Bulletin, published by the Arthritis and Rheumatism Foundation, is issued nine times a year and is available without charge to all physicians and medical students who request it.

Physicians wishing to regularly receive The Bulletin on Rheumatic Diseases at no cost, should write to Dr. Russell L. Cecil, Medical Director, Arthritis and Rheumatism Foundation, 23 West 45th Street, New York 36, N.Y.

The bound special volume composed of all issues of The Bulletin of the past four years, is available from the Arthritis Foundation at the cost of \$1.

The Bulletin, the only American publication in the field of the rheumatic diseases, was started in 1950 to foster greater interest in the rheumatic diseases among physicians. Its aim is to keep doctors abreast of the more important clinical advances and changing concepts of the rheumatic diseases promptly, simply and succinctly.

The Bulletin at present is being distributed to 22,500 physicians throughout the United States and 25 foreign countries.

## WANTED FOR ROBBERY

Post Office Inspector  
Rock Island, Ill.

September 29, 1954

Information: George Edward Payne, trigger man in hold-up of station 15 of Indianapolis, Ind. Post Office. (warrant for arrest—U.S. Marshall, Indianapolis)

Last seen E. St. Louis, Illinois, Sept. 10, 1954. Numerous reports indicate that Payne requires periodic attention of a doctor. One report states



that Payne is suffering from a kidney disorder that requires him to carry a rubber tube for the purpose of irrigating his kidneys. Another report states that it is necessary for him to visit a physician at least once each month for the purpose of draining his kidneys or perhaps a lung. Previous reports concerning lung and/or kidney ailments of Payne have been received.

Description: George Edward Payne,  
alias Ed Brown and George Brown.

White; 30 years of age; born Nov. 2, 1923. Height, 5' 11"; weight, 165 to 180 pounds. Dark brown eyes, medium complexion, dark brown wavy hair and soft spoken.

Payne has a mole on his left cheek; two small scars on his forehead; and his upper front teeth are missing, but may have been replaced by false teeth. He frequently wears a mustache. He has a blue tattoo of a girl's head on his inner forearm; a tattoo of "Joe" on his outer forearm; a blue tattoo of the numeral "13" on the base of his left thumb; and a blue tattoo of a bird on his upper forearm with letters "PAT" inset.

W. J. Arp,  
P.O. Inspector  
Rock Island, Ill.

## GRANTS-IN-AID, CANCER RESEARCH

The American Cancer Society, Illinois Division, Inc., has been the beneficiary of several legacies and has, therefore, limited funds which it is desired to expend for the support of responsible cancer research projects. Accordingly, applications will be received for grants-in-aid for cancer research to be considered by a special committee. Applications will be considered for continuing, one to five year projects, contingent upon the availability of funds.

Application forms may be obtained from John A. Rogers, M.D., Executive Director, American Cancer Society, Illinois Division, 139 North Clark Street, Chicago.

Applications should contain full details concerning the nature of the project and what is hoped in the way of accomplishment. Sufficient information should be supplied to assure the committee that personnel concerned in the research is qualified and that adequate facilities are available.

## INVITATION TO ATTEND JAMAICA MEDICAL MEETING

Members of our State Society attending the AMA Interim meeting in Miami are invited to a post-convention meeting of the British Medical Association, Jamaica Branch, at Kingston, capital city of the Island, on Saturday, December 4, at 10:00 A.M.

The invitation comes direct from the president and officers of the Jamaica Association, which was founded in 1877.

Jamaica is reached from Miami by airliner in a pleasant 2½ hour trip over the Gulf Stream, across Cuba and a corner of the Caribbean Sea. Following the close of the AMA meeting on Thursday, December 2, doctors and their wives could fly to Jamaica on Friday, attend the British Medical meeting Saturday forenoon, December 4, then enjoy the attractions of the popular tourist island as long as desired, returning to Miami by several daily air schedules in about three hours.

Further details will be available at Information Desks at the Miami meeting, from American Express Company and local travel agents, or from the Miami office of the Jamaica Tourist Board, 1631 duPont Building.

## **MIDWINTER SEMINAR IN OPHTHALMOLOGY AND OTOLARYNGOLOGY**

The ninth annual University of Florida Midwinter Seminar in Ophthalmology and Otolaryngology will be held at the Sans Souci Hotel in Miami Beach the week of January 17th., 1955. The lectures on Ophthalmology will be presented on January 17th, 18th, and 19th and those on Otolaryngology on January 20th, 21st, and 22nd. A midweek feature will be the Midwinter Convention of the Florida Society of Ophthalmology and Otolaryngology on Wednesday afternoon, January 19th, to which all registrants are invited. The registrants and their wives may also attend the informal banquet at 8 p.m. on Wednesday. The Seminar schedule permits ample time for recreation.

The Seminar lecturers on Ophthalmology this year are: Dr. William F. Hughes, Jr., Chicago; Dr. Phillips Thygeson, San Jose; Dr. James Allen, New Orleans; Dr. Walter H. Fink, Minneapolis; and Dr. Milton L. Berliner, New York. Those lecturing on Otolaryngology are: Dr. Paul Holinger, Chicago; Dr. Lawrence R. Boies, Minneapolis; Dr. Edmund P. Fowler, Jr., New York; Dr. Arthur W. Proetz, St. Louis; and Dr. David D. DeWeese, Portland, Oregon.

For additional information write to Shaler Richardson, M.D., 111 West Adams St., Jacksonville, Florida.

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## **U. S. CIVIL SERVICE EXAMINATIONS**

New examinations have been announced by the U. S. Civil Service Commission for filling Medical Officer positions in certain Federal agencies as follows: Positions of Medical Officer, paying \$5,940 and \$7,040 a year and Medical Officer (Specialist), paying \$8,360 to \$10,800 a year, will be filled in various agencies in Washington, D. C., and vicinity, and in the U. S. Public Health Service and the Children's Bureau, located throughout the United States. Positions of Medical Officer paying \$7,425 to \$10,450 a year, will be filled in the Panama Canal Company-

Canal Zone Government Organization in the Panama Canal Zone.

To qualify for these positions, applicants must be graduates of a medical school with the degree of doctor of medicine. For most of the Medical Officer positions at the entrance level, applicants must have completed a full internship. For Medical Officer (Specialist) positions, applicants must have completed appropriate study or residency training in the specialized field of medicine for which application is made. Professional medical experience is required for the higher-paying positions. No written test is required.

Full information regarding these positions is given in Announcement No. 415 for Medical Officer, Announcement No. 414 (B) for Medical Officer in the Panama Canal Zone, and Examining Circular EC-27 for Medical Officer (Specialist). These notices may be consulted at most post offices or copies may be secured direct from the U. S. Civil Service Commission, Washington 25, D.C. Applications for all positions will be accepted until further notice. Applications for positions in agencies in the United States must be filed with the Commission's Washington office. For positions in the Panama Canal Zone, send applications to the Board of U. S. Civil Service Examiners, Balboa Heights, Canal Zone.

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## **AMERICAN BOARD OF OBSTETRICS AND GYNECOLOGY**

The next scheduled examination (Part I), written examination and review of case histories, for all candidates will be held in various cities of the United States, Canada, and military centers outside the continental United States, on Friday, February 4, 1955.

Case Abstracts numbering 20 are to be sent by the candidate to the Secretary as soon as possible after receiving notification of eligibility to the Part I written examination.

Candidates are reminded at this time that lists of hospital admissions must accompany new applications and requests for reopening.

Office of the Secretary—Robert L. Faulkner, M.D., 2105 Adelbert Road, Cleveland 6, Ohio.

# NEWS OF THE STATE



## ADAMS

**Ralph McReynolds Honored.**—Dr. Ralph McReynolds, Quincy, received a Distinguished Service Award from the Mississippi Valley Medical Society during its September meeting in Chicago. The award is given annually to a member of the society "who has rendered unusual and distinguished service to the medical profession." Dr. McReynolds, who was one of the organizers of the society, served as president in 1951.

**Quincy General Practitioner Group Organized.**—On September 30 the Quincy Regional Chapter of the Illinois Academy of General Practice was organized with Dr. Carl F. H. Pfeiffer as president. Other officers are Drs. E. A. Webster, vice president; George Borden, secretary-treasurer; B. C. Kappmeyer and J. Belogorsky, delegates, and H. Zingher and E. A. Griep, alternate delegates.

**Society News.**—"Clinical Application of the Electroencephalogram" was discussed by Dr. Albert E. Rauh, Springfield, before the Adams County Medical Society, October 11, at the Lincoln-Douglas Hotel, Quincy. The society was addressed in September by Drs. James A. Henderson on "Ambulatory Treatment of Meniere's Syndrome"; Hilliard M. Shair, "Treatment of the Commonest Skin Ailments," and Walter M. Whitaker, "Emergencies in the Newborn." The last paper was discussed by Daniel Landau, Hannibal, Mo., James R. Cooper, and James H. Cravens.

**Personal.**—Dr. Nicholas M. Alter, recently director of pathology at the Margaret Hague Maternity Hospital in Jersey City, N. J., is now the full-time pathologist at Blessing Hospital.—Dr. Walter Stevenson has been chosen president of Blessing Hospital staff; Dr. Kent W. Barber, vice president, and Dr. E. Newton DuPuy, secretary-treasurer.—Dr.

H. Douglas Cooper has been certified by the American Board of Otolaryngology.—Dr. Carl W. Hagler, a lieutenant commander in the U.S.N.R., was to report to Beaufort, S. C., October 18, to begin a two year tour of duty, and Dr. J. Richard Cooper was to report to Lackland Air Force Base, San Antonio, Texas, October 17.

**Business Meeting.**—The Adams County Medical Society, at its business meeting in October, approved the report of its Public Relations Committee which recommended the establishment of a Speaker's Bureau and approved the participation of society members on radio and television program. Suggestions set up by the American Medical Association were to be the pattern. Approval was also given to the report of the society's veterans Committee regarding medical care of veterans. The society also endorsed the establishment of a rheumatic fever prevention program in the schools of Quincy, under the auspices of the Adams County Chapter of the Illinois Heart Association and as recommended by the local chapter's Medical Advisory Committee. The matter of endorsing the establishment of a mental hygiene clinic in Quincy was discussed, but it was decided to consider this further at the November meeting when one of the clinical teachers of psychiatry from St. Louis will address the society.

At the meeting, Drs. Kenneth H. Keeton, Carl M. Rylander and Richard M. Street, all of Quincy, were elected to active membership in the Adams County Medical Society.

## COOK

**CMS Installs New Officers.**—New officers of the Chicago Medical Society were installed, September 29, at the annual dinner in the Furniture Club of America. They are Drs. Frank H. Fowler, presi-

dent; Maurice M. Hoeltgen, president-elect, and Norris J. Heckel, secretary.

**Twenty-Five Year Staff Members Honored.**—Twelve physicians who have been on the staff of Passavant Hospital for twenty-five years were among those honored for years of service at a special dinner, September 30. They are Drs. Isaac A. Abt, Howard B. Carroll, James T. Case, Arthur H. Curtis, Loyla Davis, Sumner L. Koch, Sigurd Kraft, Chauncey C. Maher, Lewis J. Pollock, Harry M. Richter, James P. Simonds and Eugene S. Talbot. All are members of the faculty of Northwestern University Medical School, either on an active or emeritus basis.

**Robert Black Memorial Lecture.**—Dr. Eleanor M. Humphrey, professor of pathology, University of Chicago School of Medicine, delivered the Robert A. Black Memorial Lecture, October 15, at La Rabida Sanitarium. Her subject was "Rheumatic Fever—Observations and Perspectives." Preceding the lecture, the medical staff of the sanitarium presented the following program: Robert A. Miller, Congenital Isolated Dextrocardia; Earl B. Benditt, Role of the Mast Cell in the Reaction to Acute Injury, and Sara Schiller, Ph.D., Metabolism of Mucopolysaccharides of the Ground Substance.

**Medicine and Society.**—The Chicago Medical School opened a series of lectures on Medicine and Society, October 19, with a discussion by Harry H. Garner on "Psychiatry Looks at Religion." Other lecturers include: Paul R. Hawley, October 26, Medical Care of Veterans, Rabbi Jacob J. Weinstein, November 9, Religion Looks at Psychiatry, Herman Finer, D.Sc., November 16, on Social Policy for Medical Men, Irvin M. Lourie, Washington, D.C., November 23, The World Health Organization and Its Operation and, Kurt Stern, November 30, Medicine in the Bible and the Talmud.

**Cancer Series.**—Dr. Joseph H. Burchenal of the Sloan-Kettering Institute for Cancer Research, New York, opened a weekly series of lectures on cancer, October 13, with a talk on the treatment of leukemia. The series is sponsored by Northwestern University Medical School. Other lecturers included Drs. James W. Reagan, Western Reserve University School of Medicine, Cleveland; Samuel G. Taylor III, Presbyterian Hospital; Harry Goldblatt, Mount Sinai Hospital, Cleveland; Paul E. Steiner and Charles Huggins, University of Chicago School of Medicine, and Stanley P. Reimann of Lankenau Hospital Research Institute, Philadelphia.

**St. Francis Hospital Honors Staff Members.**—A feature of the alumni homecoming program of St. Francis Hospital, Evanston, September 23 was the presentation of plaques and scrolls to two retired members of the hospital staff; Drs. I. H. Chilcott, Puente, Calif., and Ernest C. McGill, Evanston. A similar honor went to the late Dr. Charles L. Conroy and was accepted by his widow, Florence. Dr. Conroy helped organize the St. Francis medical

staff thirty-five years ago and was chief of surgery for fifteen years. Dr. Chilcott, honored for his thirty-five years of service, helped establish the blood bank in 1939, and Dr. McGill was president of the staff in 1932 and chief of obstetrics for ten years. Drs. Lorne W. Mason, Noel G. Shaw and John J. Fahey were in charge of the committees for the hospital homecoming.

**Present Day Immunologic Practices.**—The North Shore Branch of the Chicago Medical Society devoted its meeting, November 2, to a symposium on present day immunologic practices. Speakers were: Harry B. Harding, Current Advances in Vaccine Therapy with Reference to Poliomyelitis; Martin H. Seifert, Anterior Poliomyelitis—Clinical and Immunologic Aspects, and Ralph Spaeth, Practical Application of Immunologic Procedures in Children.

**Society News.**—The Chicago Diabetes Association will be addressed, November 18, at the John B. Murphy Memorial Auditorium by Dr. Priscilla White of the Joslyn Clinic and the New England Deaconess Hospital, Boston; her subject will be "Conquering Diabetes."—The Chicago Neurological Society, at its meeting in the International Relations Center, October 12, was addressed by Drs. Harold C. Voris on Five Years Survival in a Patient with Glioblastoma of the Frontal Lobe; Adrien Ver Bruggen, Ophthalmoplegic Migraine; Alex J. Arieff and Richard Crouch, Effective Temperature Regulation in Cervical Spinal Injuries, and Husameddin K. Gokay, Non-Syphilitic Interstitial Keratitis Associated with Deafness—Cogan's Syndrome.—At a meeting of the Chicago Pediatric Society, October 19, the following spoke: Drs. Alfred D. Biggs and Frederick L. Phillips, Practical Management of Erythroblastosis Fetalis in a General Hospital; Mila Pierce, Treatment of Erythroblastosis with the Exchange Transfusion; Edith Potter, Management of the Rh Negative Patient. Drs. Heyworth N. Sanford, Herbert Philipsborn, Howard Teisman and Paul Tracy discussed the presentations.

## KNOX

**Society News.**—Dr. Sidney E. Ziffren, associate professor of surgery, State University of Iowa College of Medicine, Iowa City, addressed the Knox County Medical Society, September 16, on treatment of burns. At the business meeting considerable discussion centered on the Red Cross Blood Bank and professional insurance.

## MACON

**Society News.**—Dr. Clayton G. Loosli, professor of medicine, University of Chicago School of Medicine, addressed the Macon County Medical Society, September 28, at the Decatur Club, on "Serologic Aspects in/of Infectious Diseases."

## MADISON

**Society News.**—"Newer Laboratory Diagnostic Procedures" was discussed by Theodore E. Weichselbaum, Ph.D., clinical biochemical consultant to the Hospitals of the City of St. Louis, St. Luke's

Hospital, St. Louis, Air Training Command, U.S.A.F., and St. Joseph's Hospital, Alton, addressed the Madison County Medical Society at St. John's Methodist Church, Edwardsville, October 7. The society was addressed at its September meeting by Dr. Charles Eckert, St. Louis, on "Some Surgical Principles in the Management of Cancer."

### ROCK ISLAND

**Society News.**—Dr. R. T. Tidrick, professor of surgery, State University of Iowa College of Medicine, Iowa City, discussed "Surgical Conditions in Early Infancy" before the Rock Island County Medical Society at the Moline Public Hospital, October 12.

### PEORIA

**Society News.**—Dr. Francis L. Lederer, Chicago, addressed the Peoria Medical Society at the University Club, Peoria, October 19, on "Facts, Fancies and Foibles in Otolaryngology."

### SANGAMON

**Society News.**—Dr. Philip A. Tumulty, St. Louis, addressed the Sangamon County Medical Society at the Elks Club, October 7, on "Disseminated Lupus Erythematosus." The society held its fall picnic, October 21, in the Officers Club, State Fair Grounds.

**Medical Staff Organized at St. John's.**—The many months of preparation of proposed by-laws for an organized staff by the St. John's Hospital Board culminated in their unanimous approval and acceptance by all the physicians in attendance at a meeting for this purpose on September 8. Dr. George Stericker acted as chairman, pro tem, and Dr. Robert Nachtwey, secretary, until the by-laws were adopted and officers elected.

Dr. H. B. Henkel, Sr., was elected president of the staff; Dr. Frank Davis, vice president; and Dr. William DeHollander, secretary.

The completion of the organization took place during the week of September 20-27, when the various departments met for the purpose of electing their officers, consisting of a chairman, vice-chairman, and secretary. The chairmen of these various departments will form the executive board of the staff.

Department of General Practice: Chairman, Dr. Paul LaFata; Vice-chairman, Dr. Jacob E. Reisch; Secretary, Dr. K. D. Kohlstedt.

Department of Obstetrics and Gynecology: Chairman, Dr. H. L. Penning; Vice-chairman, Dr. William W. Curtis; Secretary, Dr. Victor H. Beinke.

Department of Pediatrics: Chairman, Dr. Oliver E. Ehrhardt; Vice-chairman, Dr. A. R. Eveloff; Secretary, Dr. Charles N. Christensen.

Department of Medicine: Chairman, Dr. Thomas D. Masters; Vice-chairman, Dr. Richard Allyn; Secretary, Dr. Henry S. Bernet.

Department of Surgery: Chairman, Dr. Frank M. Davis, Vice-Chairman, Dr. Franz K. Fleischli; Secretary, Dr. Ray J. McGann.

### VERMILION

**Joint Meeting.**—"Medical Legislature as It Affects You" was the title of a talk before a joint meeting of the Vermilion County Medical Society at its Woman's Auxiliary, October 5. The speaker was Mr. John Martin of the Legislative Council of the American Medical Association. The September meeting of the society was addressed by Mr. Dave Twomey of the Danville Chamber of Commerce on "New Industries, Inc." and Dr. Arthur DeBoer, Chicago, on Surgical Emergencies of the Newborn.

### WINNEBAGO

**Conference on Mental Health.**—The fifth annual State Mental Health Conference, sponsored by the Illinois Society for Mental Health, was held at the Forest Hills Country Club, Rockford, September 30. The theme of the conference was to foster community interest in mental health. The morning panel's theme was "How I got the Mental Health Bug." Acting as chairman, Vern E. Lentz, Rockford, represented industry; others were Rev. Arthur T. Clark, Rock Island; Mrs. Ralph S. Dobbin, Springfield, mother; Dr. Morton J. Freedman, Peoria, physician; Harris B. Estes, Waukegan, board member, local community interest, and Mrs. Edison Dick, Chicago board member, statewide interest. Mrs. Dobbins was chairman of the afternoon session on "Intensifying and Spreading the "Itch" Through Participation". Panelists were Mae E. Shahee, Springfield, volunteer, relatives state hospital patients; Mrs. Dan B. Withers Jr., Elgin, volunteer—state hospital patients; Emma Lundgren, Rockford, principal—school and community; Prudence Jackson, Rockford, high school student; Sarah B. Schaar, Chicago, board member, state-wide programs. The keynote speaker at the luncheon was Dr. Paul V. Lemkau, chief of the division of mental health, Maryland State Department of Health, on "The Community Stake in Public Health." Co-sponsors of the conference were Mental Hygiene Society, Springfield; Mental Health Society of Winnebago, North Lake County Mental Health Society, Peoria Mental Hygiene Society and the Rock Island County Mental Health Society.

**Medicine for Today.**—A series of postgraduate lectures, sponsored by the Illinois Academy of General Practice, opened at St. Anthony's Hospital Auditorium, Rockford, October 7, with a discussion on office management of diabetes. Other topics in the weekly two hour lectures included prevention and management of complications of diabetes, common endocrine disorders, the steroid hormones. Clinical-pathologic sessions were included as was a talk by Dr. J. S. DeTar, Milan, Mich. The course runs through November 19 and from April 11, omitting week of May 16, through May 27, 1955. Other topics will be the common dermatoses, office problems in otolaryngology, diseases of metabolism, and the abdomen in pediatric practice.

## GENERAL

**"Your Doctor Speaks".**—Since the last issue of the Illinois Medical Journal, the following physicians have presented transcribed broadcasts in the series "Your Doctor Speaks". The series is presented by the Educational Committee of the Illinois State Medical Society in cooperation with FM Station WFJL.

**Lowell F. Peterson**, clinical instructor in obstetrics and gynecology, University of Illinois College of Medicine, September 30, on Prenatal Care.

**George J. Gertz**, attending surgeon, Jackson Park Hospital, October 7, on Accidental Emergencies.

**Harvey White**, head of radiology department, Children's Memorial Hospital, October 14, on X-Ray and Your Child.

**Robert L. Craig**, department of surgery, Evanston Hospital, October 21, on Medical Research.

**"All About Baby".**—Since the last issue of the Illinois Medical Journal, the following physicians have appeared on the telecast "All About Baby" over WBKB, Channel 7, under the auspices of the Educational Committee of the Illinois State Medical Society:

**Thomas P. Saltiel**, member of the attending staff, St. Joseph's Hospital, September 22.

**Bernard Gumbiner**, instructor in pediatrics, Northwestern University Medical School.

**L. Martin Hardy**, associate in pediatrics, Northwestern University Medical School, October 13.

**Lawrence Breslow**, clinical assistant professor of pediatrics, University of Illinois College of Medicine, October 20.

**Lectures Arranged Through the Educational Committee of the Illinois State Medical Society:**

**W. W. Fullerton**, Sparta, Okawville Woman's Club in Okawville, October 14, on Understanding the Adolescent.

**Joseph T. O'Neill**, Ottawa, Sheridan PTA in Sheridan, October 18, on Health of the School Child.

**Arthur H. Rosenblum**, Dixon School PTA in Chicago, November 3, on Physical and Emotional Development of School Age Children.

**John A. Mart**, University Club of Park Ridge in Park Ridge, November 8, on What's New in Research on the Heart.

**Lawrence Breslow**, Ogden School PTA in Chicago, November 18, on Health of the School Child.

**Maurice A. Schiller**, Women's Auxiliary to the Aux Plaines Branch of the Chicago Medical Society in Oak Park, November 18, on Mental Health.

**Lectures Arranged Through the Scientific Service Committee of the Illinois State Medical Society:**

**Eugene L. Slotkowski**, Bureau County Medical Society in Spring Valley, June 8, on Advances in Pediatrics.

**Thomas Masters**, Springfield, Macoupin-Montgomery County Medical Society in Carlinville, September 28, on Diabetes.

**Edwin R. Levine**, Chicago, LaSalle County Med-

ical Society in Ottawa, October 14, on Management of Tuberculosis and Its Imitators.

**Lawrence Breslow**, Stock Yards Branch, Chicago Medical Society, October 15, at Evangelical Hospital, on Pediatric Diarrheas.

**William N. Sauer**, St. Louis, Montgomery-Macoupin County Medical Societies, October 20, in Litchfield, on Deafness, Dizziness and the Fenestration Operation.

**E. Clinton Texter, Jr.**, Knox County Medical Society in Galesburg, October 21, on Medical Management of Peptic Ulcer.

**James P. Greenhill**, La Salle County Medical Society in LaSalle, November 11, on What's New in Obstetrics and Gynecology.

**Walter C. Bornemeier**, Douglas Park Branch of the Chicago Medical Society at the MacNeal Memorial Hospital, Berwyn, November 23, on Ethics and Economics.

**E. Lee Dorsett**, St. Louis, Montgomery-Macoupin County Medical Societies in Litchfield, December 8, on Obstetrical Emergencies.

**Norris J. Heckel**, La Salle County Medical Society in LaSalle, December 9, on Carcinoma of the Bladder.

**Postgraduate Conferences.**—The Postgraduate Education Committee of the Illinois State Medical Society, in cooperation with the staff of Michael Reese Hospital, Chicago, presented a postgraduate conference in Decatur, October 21, with the Macon County Medical Society acting as host. Speakers were Drs. Rachmiel Levine, Newer Aspects of the Diagnosis and Therapy of Thyroid Disease"; Ernest Mond, Anemia and Abnormal Hemoglobin; Bernard Eisenstein, Diabetic Acidosis and Coma; Charles Schiff, Acute Abdominal Emergencies, and Earl Silbert, Myocarditis. At the dinner, Dr. Levine spoke on Recent Advances in Adrenal Cortical Function. Another conference was presented in Freeport, October 13, in cooperation with the faculty of the University of Illinois College of Medicine, and with the Stephenson County Medical Society acting as host. Participants were Drs. Charles B. Puestow, Benign Pancreatic Disease; Hyman J. Zimmerman, Management of Hepatitis; Heyworth N. Sanford, Diarrhea in Infancy; Edmund F. Foley, Headache; Lindon Seed, Radioactive Iodine in Thyroid Disease, and John R. Wolff, Use of Pituitary Extract in Labor. Dr. Leroy Sloan gave the dinner address on "Medical Miscellany and the Doctor's Wife."

**June Ramsey Retires.**—Miss June A. Ramsey, Chicago, has retired as executive secretary of the Illinois State Nurses Association, effective September 1. She had held the position for more than eleven years. Her successor is Mrs. Anne Zimmerman.

**Chicago Physicians Named to National Office.**—Dr. Howard Wakefield has been named chairman of the subspecialty board on cardiovascular disease of the Scientific Council of the American Heart Asso-

ciation to serve for two years. The board examines candidates for certification as cardiologists by the American Board of Internal Medicine and advises the American Medical Association in certifying hospitals for residency in this specialty.—Dr. Paul C. Hodges, professor and chairman of the department of roentgenology, University of Chicago School of Medicine, was chosen president-elect of the American Roentgen Ray Society recently.

**Maud Slye Dies.**—Maud Slye, Ph.D., famed pathologist and pioneer in cancer research, died in Billings Hospital, September 17, of a heart condition. At the time of her death, Dr. Slye was associate professor emeritus of pathology at the University of Chicago School of Medicine.

### DEATHS

MILTON MADDOX BRADLEY, retired, Chatham, who graduated at Marion-Sims College of Medicine, St. Louis, in 1892, died August 2, aged 90, of shock as the result of a fall.

THOMAS CARTER DOUGLASS, Chicago, who graduated at Northwestern University Medical School in 1935, died October 9, aged 46. He was associate professor of surgery at Northwestern and a member of the Illinois State Medical Society.

EDWARD W. ENOS,\* Alton, who graduated at Hering Medical College in 1910, died September 27, aged 69.

GEORGE WALTON GORE, Goreville, who graduated at St. Louis College of Physicians and Surgeons in 1905, died July 8, aged 80, of acute congestive heart failure.

JOSEPH A. GUERTIN,\* Kankakee, who graduated at Rush Medical College in 1900, died September 18, aged 82, in St. Mary's Hospital, Kankakee, of injuries suffered when he fell into a sunken driveway in his home.

HOWARD J. HOLLOWAY, Evanston, who graduated at Boston University School of Medicine in 1924, died October 6, aged 55. He was a member of the Illinois State Medical Society, associate in obstetrics and gynecology at Northwestern University Medical School, and a member of the staff at Evanston Hospital.

JOHN MARTIN JACOBS,\* retired, Elgin, who graduated at Illinois Medical College, Chicago, in 1903, and College of Physicians and Surgeons of Chicago, School of Medicine of the University of Illinois in 1906, died in Elgin State Hospital, July 28, aged 76, of bronchopneumonia.

RALPH KING,\* Olney, who graduated at the University of Illinois College of Medicine in 1916, died July 26, aged 67, of injuries received in a fall.

JOHN A. LITTLE, retired, Evanston, who graduated at Rush Medical College in 1898, died in Burbank, California, June 7, aged 85, of cerebral thrombosis with encephalomalacia.

MATTHIAS E. LORENZ, retired, Chicago, who graduated at the College of Physicians and Surgeons of Chicago in 1894, died October 6, aged 84. He formerly served as chief medical inspector of the Bridewell.

JOSEPH S. LUNDHOLM,\* Rockford, who graduated at the University of Illinois College of Medicine in 1913, died October 7, aged 63. He was Councilor for the First District of the Illinois State Medical Society.

PAUL E. MINTER,\* Wilmette, who graduated at Northwestern University Medical School in 1939, died September 26, aged 40.

CARLYLE H. MOORE,\* Vandalia, who graduated at Barnes Medical College, St. Louis, in 1896, died July 22, aged 80, of myocarditis.

DILLON GARRETT O'NEIL,\* Chicago, who graduated at Georgetown University School of Medicine, Washington, D. C., 1913, died in the Veterans Administration Hospital in Hines, July 31, aged 67, of bilateral bronchopneumonia.

PAUL DAVID PRESSL,\* Chicago, who graduated at Medizinische Fakultät der Universität, Vienna, Austria, in 1923, died in the Columbus Hospital, August 19, aged 64.

EDMUND A. PROBY,\* Chicago, who graduated at Loyola University School of Medicine in 1928, died October 12, aged 54. He was a member of the staff of South Shore Hospital.

JAMES P. RYNNE,\* Chicago, who graduated at Loyola University School of Medicine in 1943, died September 29, aged 36. He was a member of the staff of the Little Company of Mary Hospital.

MARVIN J. TAMARI,\* Chicago, who graduated at Medizinische Fakultät der Universität, Vienna, Austria, in 1925, died October 11, aged 60. He was associate professor of otolaryngology at the University of Illinois College of Medicine.

\*Member of the Illinois State Medical Society.

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### NURSING EDUCATION (Continued)

Bloomington, Quincy, Taylorville, Ottawa, and so on, for another eighteen months to two years of straight bedside training. This would tend to remove part of the costs of nursing education

ultimately paid for by the patient.

It would seem to me that in the present circumstances the trend of nursing education is developing without enough guidance on the part of physicians.

# Meat...

## *and Its Contribution to Fat Needs*

Fat, the most concentrated source of nutrient energy, constitutes a dietary essential in human nutrition.<sup>1</sup> It is needed in growth and replacement of tissues, for specific lipid secretions, and for providing physiologic energy.<sup>1,2</sup> Absorbed fatty acids may be incorporated into more complex lipids, deposited in adipose tissue, converted into other fatty acids, used in production of milk fat, transformed into glucose or glycogen, or oxidized to carbon dioxide and water with liberation of energy.<sup>3</sup>

Evidence indicates that long continued extremely low fat intake in adults is incompatible with good health.<sup>4,a</sup> In addition to protecting tissue protein against catabolism for energy needs (the protein-sparing action of fat), sufficient amounts of fat in the dietary promote storage of protein.<sup>4,b</sup> In a normal mixed diet, fat is about 95 per cent as efficient as carbohydrate for production of muscular work.<sup>4,c</sup>

Neither the optimal level of fat in the diet nor the optimal range for apportionment of fat and carbohydrate to meet calorie allowances is known.<sup>1,2</sup>

Contrary to general impressions, fat in the mixed diet is effectively digested.<sup>4,d</sup> In moderate amounts it does not appreciably influence the digestibility of other foods.<sup>5</sup> Fat enhances the satiety value of meals, and foods naturally containing fat and those prepared with fat add much to the flavor value of meals. High fat diets sometimes are useful in alleviating constipation.<sup>6</sup>

Meat, according to its kind and cut, provides variable amounts of fat which contribute importantly to the body's need for fat. The fat of meat is almost completely digested. Meat also supplies valuable amounts of high biologic quality protein, B vitamins, and essential minerals. Skeletal muscle meat contains less than 0.1 per cent of cholesterol.<sup>7</sup>

1. Goldsmith, G. A.: Application to Human Nutrition, in Bourne, G. H., and Kidder, G. W.: *Biochemistry and Physiology of Nutrition*, New York, Academic Press Inc., 1953, chap. 23, p. 505.
2. Recommended Dietary Allowances, Washington, D. C., National Academy of Sciences—National Research Council, Publication 302, 1953, p. 23.
3. Ekstein, H. C.: Fat in Nutrition, in *Handbook of Nutrition, A Symposium*, ed. 2, Philadelphia, The Blakiston Company, 1951, p. 23.

4. Sherman, H. C.: *Chemistry of Food and Nutrition*, ed. 8, New York, The Macmillan Company, 1952, (a) p. 30; (b) p. 198; (c) p. 115; (d) p. 103.
5. McLester, J. S., and Darby, W. J.: *Nutrition and Diet in Health and Disease*, ed. 6, Philadelphia, W. B. Saunders Company, 1952, pp. 130-135.
6. Smith, F. H.: The Use of High Fat Diets for Constipation, *J.A.M.A.* 88:628 (Feb. 26) 1927.
7. Okey, R.: Cholesterol Content of Foods, *J. Am. Dietet. A.* 21:341 (June) 1945.

The Seal of Acceptance denotes that the nutritional statements made in this advertisement are acceptable to the Council on Foods and Nutrition of the American Medical Association.



**American Meat Institute**  
Main Office, Chicago...Members Throughout the United States

## BOOK REVIEWS



**THE THYROID:** A Physiological, Pathological, Clinical and Surgical Study. By T. Levitt, M.A., F.R.C.S. (Eng.). F.R.C.S. (Ed.), F.R.C.S.I. Hunterian Professor of the Royal College of Surgeons of England; Lecturer in Surgery to the Fellowship of Postgraduate Medicine at the New End Hospital, Hampstead, London; sometime Surgeon, Paddington Hospital, London; First Surgical Assistant, Thyroid Clinic, New End Hospital, London; Demonstrator in Anatomy, Middlesex Hospital, University of London. Cloth. \$20. Pp. 606, with 43 tables and 502 figures (some in color). Williams & Wilkins Company, Mount Royal and Guilford Aves., Baltimore 2; E. & S. Livingstone, Ltd., 16 and 17 Teviot Pl., Edinburgh 1, 1954.

This is a beautiful book. It is well written in excellent English. The illustrations, particularly the colored plates, are well done and so arranged as to be helpful in following the text. The preface and the introduction should be read.

The body of the book is divided into three sections: Section I The Natural History of Thyroid Disease, 185 pages; Section II The Clinical Aspect of Thyroid Disease, 308 pages; Section III Treatment, 42 pages.

The book was written after 25 years' study by the author. During that time he examined specimens from more than 2000 thyroidectomies. He has studied these from the clinical, macroscopic

and microscopic points of view. As a result of these studies, plus a survey of the world literature on the subject, Dr. Levitt offers a new classification and nomenclature correlating the clinical findings with the macroscopical and microscopical appearances of the diseased gland. He suggests six progressive phases of the toxic thyroid gland, as follows: "1. Epithelial hyperplasia; 2. Lymphoepithelial hyperplasia; 3. Focal lymphoid hyperplasia; 4. Diffuse lymphoid hyperplasia; 5. Fibro-lymphoid hyperplasia; 6. Fibrosis."

He seems more positive than most writers of the role played by the pituitary.

Every one interested in thyroid disease will want a copy of this magnificent book. J.H.H.

### THEORY-PROBLEMS OF ADOLESCENT DEVELOPMENT

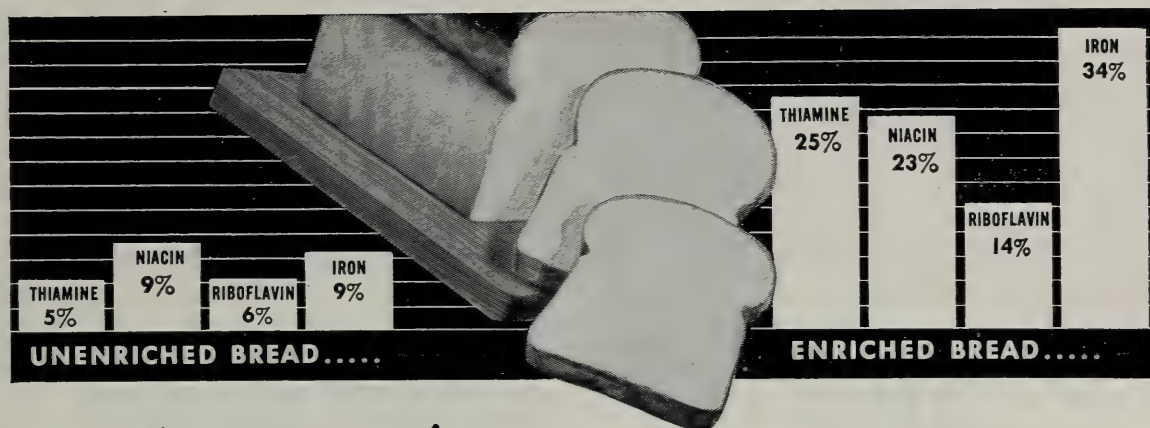
David P. Ausubel

Grune & Stratton, Inc., New York — \$10

"This book is primarily intended as an advanced textbook in adolescent psychology for graduate students in psychology and education". So states the author in his preface.

While the author has a medical degree as well as his degree in psychology his affiliation with the Bureau of Educational Research at the University of Illinois in Champaign is the only one mentioned in the book. The format and tone of the book also reflect the approach

*(Continued on page 56)*



## Note the Nutritional Difference

THE superior nutritive value of enriched bread over unenriched bread is emphasized by analytical data recently published by the United States Department of Agriculture.<sup>1</sup> Comparison of the two kinds of bread indicates how much more effectively enriched bread contributes to nutritional needs.

Since enriched breads represent an estimated 85 per cent of all commercially produced bread, the evidence shows that bread enrichment has notably increased the B vitamin and iron intake of our population. For this reason enriched bread, since 1941 (when it was first marketed), has been a valuable aid in reducing the incidence of attributable deficiency diseases.<sup>3,4</sup>

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At notably low cost, enriched bread is making a valuable contribution to the nutritional health of the American people.

1. Watt, B.K., and Merrill, A.L.: Composition of Foods—Raw, Processed, Prepared, United States Department of Agriculture, Agricultural Handbook no. 8, 1950.
2. Data furnished by the Laboratories of The American Institute of Baking, Chicago, Illinois.
3. Sebrell, W.H., Jr.: Trends and Needs in Nutrition, J.A.M.A. 152:42 (May 2) 1953.
4. Flour and Bread Enrichment, 1949-50, The Committee on Cereals, Food and Nutrition Board, National Research Council, 1950.



The Seal of Acceptance denotes that the nutritional statements made in this advertisement are acceptable to the Council on Foods and Nutrition of the American Medical Association.

B VITAMIN AND IRON CONTRIBUTION OF 5½ OUNCES\* OF ENRICHED AND UNENRICHED BREADS AND PERCENTAGES OF RECOMMENDED DAILY ALLOWANCES\*\*

	ENRICHED BREAD		UNENRICHED BREAD (of former years)	
	Amounts	Percentages of Recommended Daily Allowances	Amounts	Percentages of Recommended Daily Allowances
THIAMINE	0.37 mg.	25%	0.08 mg.	5%
NIACIN	3.40 mg.	23%	1.40 mg.	9%
RIBOFLAVIN	0.23 mg.	14%	0.09 mg.	6%
IRON	4.10 mg.	34%	1.10 mg.	9%

\*An estimated amount of bread consumed daily by the average person.

\*\*Daily dietary allowances (1953) recommended by the National Research Council for a fairly active man 45 years of age, 67 inches in height, and weighing 143 pounds.

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BOOK REVIEWS (Continued)

of the educational psychologist rather than the clinician.

The book contains 17 chapters divided into four parts. Part One consists of a 50 Page introduction. Part Two (258 pages) considers Psychobiological Problems. The 70 pages on the anatomy and physiology of adolescence will contain nothing new to the physician. The chapters on psychological accompaniments of bodily change, personality maturation, parent-child relationships, moral and religious development and intellectual growth of adolescents present a survey of these areas which may be somewhat less familiar to the practicing doctor.

Part Three is a 189 page consideration of the sociology and anthropology of adolescence. Topics discussed are the place of the adolescent in the wider community, his relationships with others of his age group, the sexual behavior of the adolescent and his school.

Part Four consists of a very sketchy, over generalized consideration of behavior disorders and delinquency in 30 pages and an additional 12 pages are similarly devoted to mental hygiene

and guidance.

The style of the book is pedantic. Each chapter has around 50 bibliographic references and in many instances the author has quoted rather extensively from these. The book has an author index as well as a subject index. Both are excellent.

J.O.E.

BOOKS RECEIVED

The following books have been received for reviewing, and are herewith acknowledged. This listing should be considered as a sufficient return for the courtesy of the sender. Books that appear to be of unusual interest will be reviewed as space permits each month. Readers desiring additional information relative to books listed, may write the Editor who will gladly furnish same promptly.

BABCOCK'S PRINCIPLES AND PRACTICE OF SURGERY: Edited by Karl C. Jonas, B. S., M. D., M. S., (Surg.) F. A. C. S., F. I. C. S., Department of Surgery, Temple University School of Medicine and Hospital, Philadelphia, Pa., with 1006 illustrations and 10 colored plates. Lea & Febiger, Philadelphia, 1954. \$18.00.

NERVOUSNESS, INDIGESTION AND PAIN. By Walter C. Alvarez, M. D., Emeritus Professor of Medicine, University of Minnesota, (Mayo Foundation), Emeritus Consultant in the Division of Medicine, The Mayo Clinic. Popular Edition. Harper & Brothers, New York. \$3.50.

HISTORY OF MEDICAL PRACTICE  
IN ILLINOIS

To: Secretary, Illinois State Medical Society,  
P.O. Drawer 156, Monmouth, Illinois

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**Greater Safety**—Notable freedom from chronic toxicity—the agents in these combinations have not been reported to cause sensitization or chronic toxic manifestations.

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## THE LAST DAYS OF HITLER

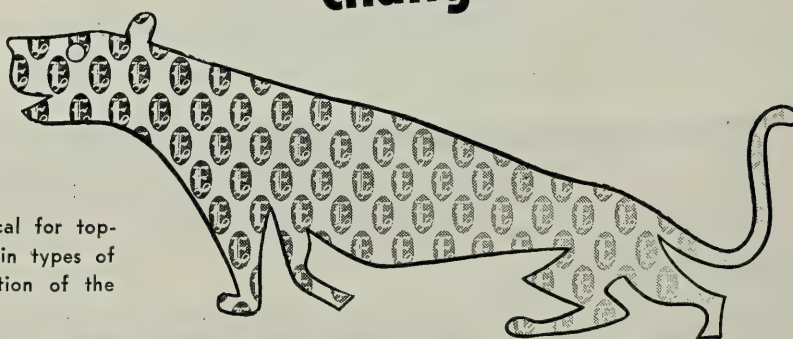
Hitler was perhaps not a normal type physically. Strict adherence to a vegetarian diet, abstinence from tobacco and alcoholic beverages, indicate certain peculiarities. It was these peculiarities, however, which gave him particular capacity for work. Since he made night into day and, moreover, shunned all physical exercise except for a little walking, the conditions of his life were rather unfavorable for good physical and mental condition, especially in view of the grueling life in shelters during the war. In addition there was also the irregularity in his mode of life occasioned by his responsibilities.

To one who had a fanaticism without equal, who believed in his mission and in final victory, the slowly increasing realization that our defeat was inevitable was bound to have a crushing effect. Consequently, at the end, he was simply a beaten man, a physical wreck who moved with slow shuffling steps, dragging his right leg, bent over with a shaking head, and a trembling hand on a limp left arm. His hand clasp was weak and soft; all his movements were that of a

senile man. Only his eyes retained their flickering gleam and penetrating look.

Despite this physical collapse, his energy and will power remained unbroken to the end. It was amazing for those of us who witnessed this each day. He worked under strain into the early morning hours until the last enemy planes had started on their return flight. The days were filled with continuous conferences and discussions on military, political, and economic problems. To the end, he preached impressively again and again to his entourage, perseverance, rigor, ruthlessness, and energy. Indicating his paralyzed arm, he stated with a sullen look, "and if my whole left side were paralyzed, I would still call on the German people again and again; do not capitulate but hold out to the end because the consequences of an unconditional surrender would be terrible in view of the Bolshevik danger." He fought against his physical decline with unbelievable rigor and determination and rose to face the irresistible fate confronting him and his people. *Captain Heinz Assman, Former German Navy, Some Personal Recollections Of Adolf Hitler. U. S. Nav. Institute Proc., Dec. 1953.*

# WHO SAYS a leopard can't change its spots?



A unique pharmaceutical for topical treatment of certain types of melanin hyperpigmentation of the human skin.

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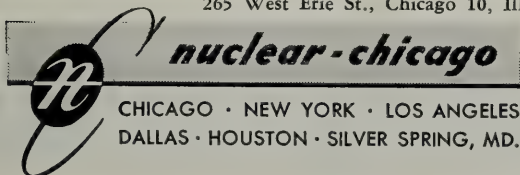
for accurate  
determination  
of thyroid  
function

using radioiodine ( $I^{131}$ )

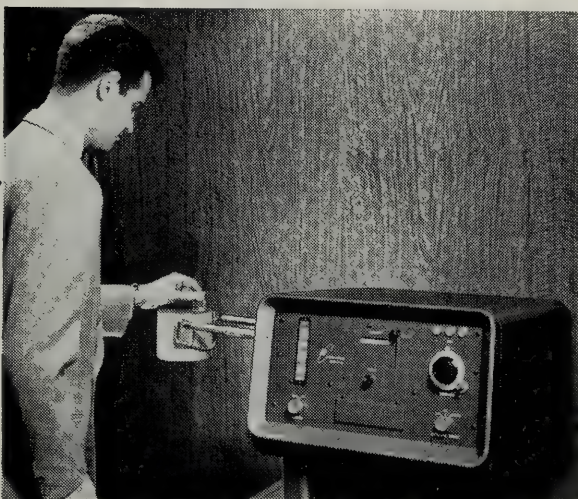
The "MEDIAC" makes measurements of thyroid activity a simple, straightforward procedure, requires no computations—takes but a few minutes. AEC requirements can be *easily* met by any physician, and the equipment cost is lower than most doctors think. The evaluation is more accurate than the BMR test, easier than the serum protein-bound iodine level, is rapidly becoming routine in hospitals, clinics and the doctor's office.

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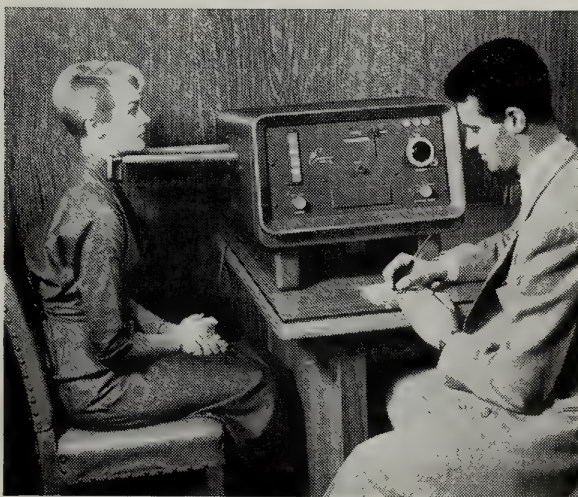
Nuclear Instrument and Chemical Corporation,  
265 West Erie St., Chicago 10, Ill.



Patient is given a radioiodine capsule or solution by mouth. An identical dose is set aside as a "standard."



After a time lapse (usually 24 hours), the "standard" is measured\* in the phantom neck. A single control then adjusts the "MEDIAC" for the patient.



Phantom is removed and activity in patient's thyroid is measured.\* Uptake of radioiodine is directly related to thyroid function and shown as a per cent of the administered dose.

\*Maximum time involved—2 minutes.

## WHY PEOPLE TURN TO QUACKERY

A sick person develops many complexes, fears, dreads, peeves, notions, and suspicions. This is particularly true if the illness is of long duration and it is usually even more accentuated if the patient has cancer. Many cancers are of long duration and the patient has constant need of a great deal of psychotherapy. If he does not get it from his family and his physician, he will seek it elsewhere. The quack usually is a pretty good psychologist and his promises of cure or relief are presented in a manner that is difficult to resist. Who hasn't wasted his money at some time or another on a "hotter spark plug inducer" or a "gasoline saver?" And are not most food fads plain quackery? Intelligent people in the best of health fall for these things by the millions. So, why wouldn't the man who is waiting to die be attracted to anything that merely promises in some way to help him? We know that the cancer patient is wasting his money and too often wasting the precious time that is his greatest hope. We know that his family and friends become impatient and often contribute to his turning to the nostrums of the

quack. The doctor does not contribute directly to this situation but he should always be cognizant of the terrific psychologic conflict that exists and should counter it with a better brand of his own psychology along with his treatment. *Rollis S. Weesner, Is Cancer Quackery Declining? J. Indiana M. A. April 1954.*

## WATCH THE COST!

It costs an awful lot to be sick these days, and though the fee to the physician is a relatively small part of the total bill, we are in some ways responsible for the rest. No physician should deny his patient everything needed but he should also think in terms of dollars here and dollars there that might be saved. Some may think that as long as the total bill runs pretty close to \$2,000, let us say, why should we worry about \$14 here and \$10 there. However, a few \$14's and \$10's saved can easily cut the bill a couple of hundred dollars and if that is done our patients will be very thankful. *G. Wilse Robinson, Jr., Editorial. Bull. Jackson Co. [Mo.] Med. Soc. June 19, 1954.*

## For the Aged and Senile Patient



## ORAL Metrazol

— to help the geriatric patient with early or advanced signs of mental confusion attain a more optimistic outlook on life, to be more cooperative and alert, often with improvement in appetite and sleep pattern.

Metrazol, a centrally acting stimulant, increases respiratory and circulatory efficiency without over-excitation or hypertensive effect.

Dose:  $1\frac{1}{2}$  to 3 grains, 1 or 2 teaspoonfuls Liquidum, or the tablets, every three or four hours.

Metrazol tablets,  $1\frac{1}{2}$  grs. (100 mg.) each. Metrazol Liquidum, a wine-like flavored 15 per cent alcoholic elixir containing 100 mg. Metrazol and 1 mg. thiamine HCl per teaspoonful.

Metrazol®, brand of pentylenetetrazol, a product of E. Bilhuber, Inc.

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## ORAL SUSPENSION and PEDIATRIC DROPS



*popular cherry flavor*

ACHROMYCIN is available in two cherry-flavored dosage forms that are highly acceptable to patients—particularly children.

The Pediatric Drops are packaged with an easy-to-read graduated dropper. The Oral Suspension, supplied as dry crystals in a 1 oz. bottle. Both Oral Suspension and Pediatric Drops, when reconstituted by the pharmacist or nurse, retain potency for two weeks at room temperature.

ACHROMYCIN, an outstanding broad-spectrum antibiotic, is relatively free from untoward side reactions and provides rapid diffusion in body tissues and fluids.

ORAL SUSPENSION (Cherry Flavor): 250 mg. per teaspoonful (5 cc.), 1 oz. bottles

PEDIATRIC DROPS (Cherry Flavor): 100 mg. per cc. (approx. 5 mg. per drop), 10 cc. bottles

\*REG. U.S. PAT. OFF.

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## PEPTIC ULCER AND SMOKING

Several years ago there were a few papers which indicated that smoking induced hyperactivity of the stomach and therefore might be undesirable for an ulcer patient. The majority of them, however, indicated quite the opposite. I have repeatedly verified this by asking groups of students whether they did not get relief from hunger pains with a cigarette. I personally think there is nothing to validate the notion that taking a patient away from smoking improves his chances of getting rid of an ulcer. Against that you frequently have the statement from people for whose opinions I have the highest regard that "I have never seen a person get rid of an ulcer if he would not give up smoking." What does this mean? It means that the more co-operative patients, the ones who took the advice of these physicians seriously, got rid of their ulcers. The others did not. Co-operative patients with ulcers won't have ulcers very long because they are the people who get well. The people who come to a doctor and are told flatly not to smoke very frequently get mad at that doctor

every time they reach into their pocket for a cigarette and find it isn't there. That sets up an attitude of hostility between patient and physician which is about the most destructive thing that can happen in ulcer therapy. In my opinion, to avoid that hostility is worth whatever risk there might be in permitting a patient to smoke. *Thomas P. Almy, M.D., The Medical Treatment Of Peptic Ulcer (Cornell Conferences on Therapy). New York J. Med. May 1, 1954.*

## NOT FOR CIRRHOSIS

ACTH or cortisone has been given to 12 patients seriously ill with cirrhosis of the liver. No definite improvement from such therapy could be noted in any patient. Three patients seemed to eat a little better. Five of our patients were comatose at the time cortisone was given. All of these patients died. Many unfavorable reports concerning the use of ACTH and cortisone are known. *Carl W. Kumpe, M.D. Medical Treatment of Portal Cirrhosis, J. Kentucky M. A., July 1954.*

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## FOR THE TREATMENT OF TUBERCULOSIS

AND OTHER CHRONIC CHEST DISEASES

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## POSTPHLEBITIC SYNDROME

An oddity of the postphlebitic syndrome is that in some cases in which the objective symptoms are slight, the subjective symptoms may be so severe as to be disabling; while in other cases the objective symptoms may be pronounced yet apparently discommode the patient hardly at all. The syndrome, which is common, is known by a variety of names, the terms most often used being thrombophlebitic syndrome, postthrombotic syndrome, chronic venous insufficiency, lower leg syndrome, and postphlebitic neurosis. Although the various terms imply differing etiological delineations, the majority of the symptoms are similar. The syndrome usually is confined to the lower extremities. It follows thrombophlebitis of a deep vein, such as the iliofemoral or the popliteal, although repeated superficial thrombophlebitis might be a factor. The inflammatory process is similar to that in milk-leg following pregnancy. The various objective phenomena that follow the attack of phlebitis are pigmentation, edema, stasis dermatitis, nutritional disturbances of the area involved, with atrophy of the subcutaneous tissues, fibrosis, recurrent attacks of thrombophlebitis and inflammation, cellulitis, and ulcerations. Evaluating the objective conditions is not difficult; the symptoms that are difficult to evaluate and that may cause considerable disability, are subjective in nature. Postphlebitic neurosis would seem to be the most apt term for them. There is a great variety of subjective sensations such as burning, numbness, pains, tingling, paresthesia, weakness, aching, and cramping in the affected extremity, and often there is little correlation between the subjective symptoms and the objective findings. *Roy J. Popkin, M.D., The Postphlebitic Syndrome. California Med. April 1954.*

The immediate value of the x-ray survey at hospitals for the mentally ill is obvious. The patients who have active tuberculosis are receiving specialized care both for their mental and for their physical illnesses. They are isolated and therefore the non-tuberculous patients are spared the insidious long-time mass exposure to a highly infectious disease which without the x-ray might go undetected. Elizabeth S. Kletzsch, NTA Bulletin, Feb., 1954.

to relieve  
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When ‘Edrisal’ alone fails to relieve pain, ‘Edrisal with Codeine’ is indicated. Because of its Benzedrine† component, ‘Edrisal with Codeine’ provides codeine’s analgesia without the undesirable depressant effects so often associated with codeine therapy.

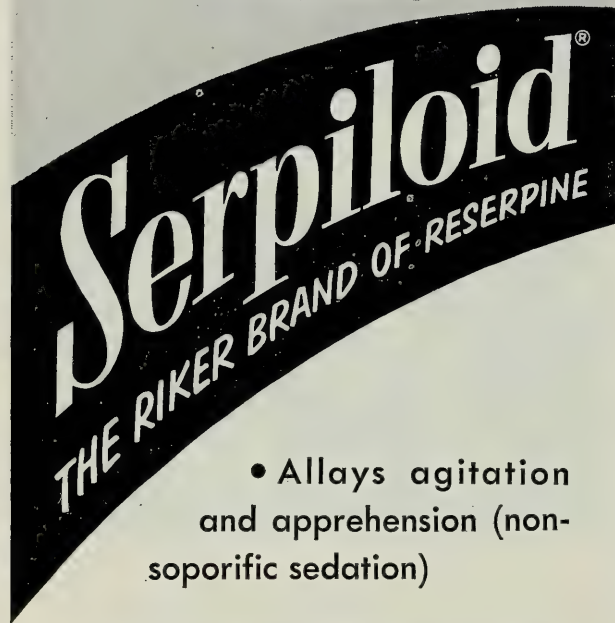
Each tablet contains codeine sulfate, ½ gr. (32 mg.)—or ¼ gr. (16 mg.)—plus the ‘Edrisal’ formula.

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## **THE EARLY HYPERTENSIVE**

Hypertension is one of the leading medical problems attacking the middle-aged man and woman. Industry rarely need worry about the patient with pre-hypertension or the neurogenic phase of hypertension. Could these people be taught how to think sensibly, live, act, relax, reduce weight and sodium intake, there need be no restriction of effort. Indeed, we need not be concerned with the patient with established essential hypertension whose vascular adaptation is fully maintained. Again, wholesome cooperation in the basic fundamentals known about the causation and treatment of hypertension is desirable. Avoidance of tension, reduction in weight, reduction in sodium intake, and a new philosophic approach toward life will keep these individuals out of vascular trouble. In addition, never before in this history of medicine, have such a host of moderately successful hypotensive agents been available to the medical profession. The hypertensive patient who demonstrates failing adaptation in some area in his body requires consideration in job placement. This may be manifested by involvement of the major sites, retinal, cerebral, cardiac, or renal. With the onset of failing adaptation, industry must be careful. Again, with an adequate history, with an encompassing physical examination, functional evaluation, utilizing sound technics available, will enable one to be guided wisely in the individual case. It is desirable to remember that males do not tolerate hypertension as well as females. It also is wise to remember that although 92 per cent of hypertensives have the garden variety of hypertension, it is heart-breaking to miss a pheochromocytoma, coarctation of the aorta, pyelonephritis, or unilateral kidney disease. *A. D. Dennison, Jr., M.D., Evaluation of The Cardiac in Industry. Indust. Med., April 1954.*

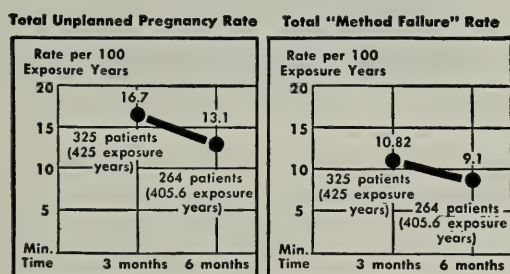
Taking reasonable action is not a simple business. To act in any personal matter with peace of mind one needs to know what one ought to do, one needs the wish and the energy to do it, and finally one must have the courage to take the consequences of what one has done. John Burton, M. D., European Conference on Health Education of the Public, London, England, April 10-18, 1953.

# PSYCHOLOGIC MOTIVATION AND CONCEPTION CONTROL

Psychologic motivation, defined as "... the sincere, urgent, uncomplicated desire to remain nonpregnant..." is an increasingly recognized factor in the success or failure of contraceptive measures.<sup>1</sup>

One of the factors influencing motivation, namely, parity, was appraised by Guttmacher<sup>1</sup> and associates in a three-year study of the jelly-alone [RAMSES® VAGINAL JELLY] method for contraception. A carefully selected group of 325 postpartum clinic patients used RAMSES VAGINAL JELLY for periods representing a total of 425 patient years of exposure. The technic showed marked effectiveness but was especially successful "among patients of lower parity."

Although the method was highly dependable, some unplanned pregnancies did occur. The pregnancies were divided into "patient failures" and "method failures." Patients readily admitting omission or irregular use of the jelly were classified in the first group, while those claiming regular and faithful use of the jelly were grouped in the latter category.



Comparison of conception control with RAMSES VAGINAL JELLY in patients using the method for 3-36 months and 6-36 months.<sup>1</sup>

During 425 patient years of exposure in 325 women using the jelly, the total unplanned pregnancy rate was only 16.7 per 100 patient years of exposure. When

the "method failure" for the entire group is calculated, the unplanned pregnancy rate drops to 10.82 per 100 patient years of exposure. When only those patients who used the jelly-alone technic for six months and longer are considered (the usual length of time accepted for valid comparisons) the pregnancy rate is decreased markedly. This indicates that familiarity with and reliance on the method are probably also important. In 264 such patients, during 405.6 patient years of exposure, the total unplanned pregnancy rate was only 13.1 per 100 years of exposure, and the method failure rate dropped to 9.1 per 100 years of exposure.

## Fitting the method to the patient

It has been demonstrated that motivation, parity, and patient-intelligence play important roles in the selection and the successful use of a conception control method and, therefore, that the final decision regarding the selection of method must be left to the physician who is fully cognizant of all these points.

When in the judgment of the physician, parity, anatomic factors, or motivation indicates the use of the diaphragm-and-jelly method of contraception, the RAMSES® TUK-A-WAY® Kit is recommended. The RAMSES® diaphragm is flexible and cushioned — provides an optimum barrier and utmost comfort. In combination with RAMSES jelly it offers an unsurpassed contraceptive technic. Both products are accepted by the appropriate Councils of the American Medical Association.

\*Active agent, dodecaethyleneglycol monolaurate 5%, in a base of long-lasting barrier effectiveness.

1. Finkelstein, R.; Guttmacher, A., and Goldberg, R.: *Am. J. Obst. & Gynec.* 63:664, Mar., 1952.

JULIUS SCHMID, INC. *gynecological division*  
423 West 55th Street, New York 19, N.Y.

## TREATMENT OF C-U TUBERCULOSIS

Relatively few drugs are used in present day chemotherapy of genitourinary tuberculosis. Tuberculin, chaulmoogra esters, promine, diasone, and tibione, among others, are being used to some extent. The tubercle bacillus is a facile organism with remarkable adaptive features. It may be susceptible to a combination of therapeutic agents which act synergistically and yet are in such low concentration that bacterial resistance develops slowly. Isonicotinic hydrazide (INH) is dramatically effective for a short time but should be used in conjunction with streptomycin or paraaminosalicylic acid (PAS) or both. Their total effect is such that reproduction, invasive features, and toxicity of the mycobacterium may be altered permanently. Recent use of INH labeled with radio active carbon has indicated a higher concentration of the agent in the dense caseous tissue than in the more fluid caseous material. This activity is enhanced by diffusion into the erythrocytes and monocytes. Streptomycin is not diffused into the tissues and even less into the monocytes. The usual dosage

is 100 mg. of INH, given by mouth thrice daily, and 1 gm. of streptomycin given subcutaneously twice a week over a period of one year. Additionally, 12 gm. of PAS may be given daily by mouth. Corper expressed the belief that no therapeutic agent can eliminate the bacillus in vivo or in vitro in a shorter time. He considered these drugs to be retardants of the organism at best. Spurious conclusions have been drawn regarding the bacterial efficacy of the drugs because the patient was improved clinically. *Donald C. Malcolm, M.D., Current Views On Genitourinary Tuberculosis. California Med. April 1954.*

## HOME CARE

Home care, as a function of the official health agency, is a rational development in view of the tremendous problem of chronic disease. Home care is a means of economy not only in money but also in more effective use of professional personnel. *Panel. Public Health Manpower to Meet Changing Health Needs. Pub. Health Rep., July 1954.*

successful in the treatment

of ulcerative colitis... **Azulfidine**®  
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**1950** *Bargen reports that since 1949 approximately 100 patients have been treated with Azulfidine. "The results have been extremely satisfactory in most cases."*

Personal communication (Apr. 12, 1950)

**1951** *Of 119 patients treated with Azulfidine prior to 1944, 90 patients (75%) were symptom-free or considerably improved when re-examined in 1949.*  
Svartz, N.: Acta. Med. Scandinav. 141:172, 1951.

**1952** *In a series of 52 patients with chronic ulcerative colitis 30, or 58%, showed significant improvement after treatment with Azulfidine.*

Morrison, L. M.: Gastroenterology 21:133, 1952.

**1953** *Morrison says: "Azopyrine [Azulfidine] . . . has been effective in controlling the disease in approximately two-thirds of patients who had previously failed to respond to standard colitis therapy currently in use."*

Morrison, L. M.: Rev. Gastroenterology 20:744 (Oct.) 1953.

*literature available on request from:*

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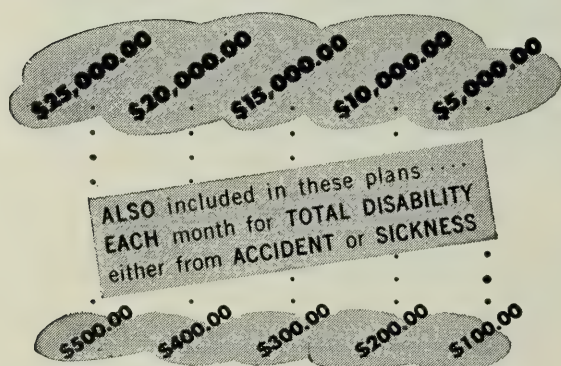
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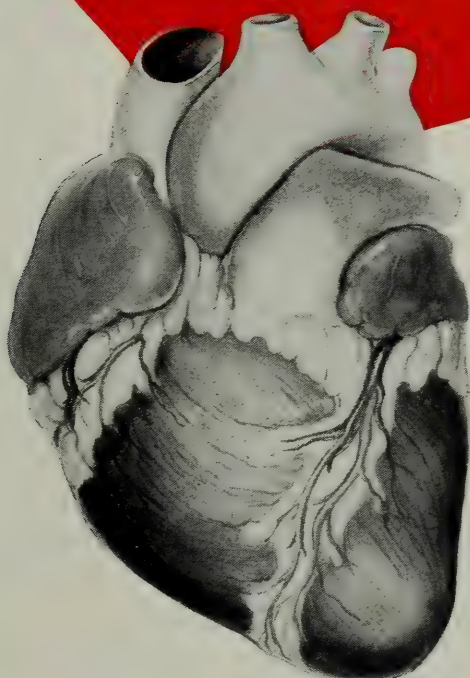
## A SICK PROFESSION?

Magazines, journals, and newspapers are ablaze with criticism of the evils of overspecialization, fee splitting, unnecessary medication and surgery, and neglect by doctors to give patients the time and personal attention they pay for. After 30 years as a college physician catching the repercussions of public criticism of our profession in addition to my daily work of caring for 2,700 students, I am inclined to believe that much of the criticism is justified. Never in history has the art of medicine moved forward at so rapid a pace as at present. Men and women who have chosen medicine as a profession are straining every nerve to keep apace with medical progress. At the same time the high cost of living has caused a nervous tension and hysteria which have permeated every business enterprise. This complex has raised incomes but has inflated prices of every commodity far beyond the compensating incomes. This vicious circle of living has rolled into the doctor's office, and overcharging by the physician is but an effort to keep up with the procession. But the medical profession is dealing with human lives, not stocks and bonds, and with human beings broken in body and spirit. The late Dr. William Osler, one of the greatest physicians of them all, said, "Know your patient first, and the disease afterward," and our own Hippocratic Oath stresses curing of the patient and not the fee as of greatest importance. *A Cure For A Sick Medical Profession.* *Texas J. Med. Dec. 1953.*

## VITALITY AND ENDURANCE

We have not given enough attention to the utilization of our vital forces because medicine, and perhaps society as a whole, is addicted to deficiency-finding instead of ability-finding. People of advanced age, wherever we meet them, are living examples of high-powered vitality and endurance; otherwise they would no longer be alive. In future geriatric research, we should concentrate more on what keeps these people alive than on what makes people die. Old people are experienced and proved survivors. This extraordinary quality of survival, which has very little to do with their actual state of health, is the great geriatric secret we have to uncover. *Martin Gumpert, M.D., Geriatrics — A Social Problem.* *J. M. Soc. New Jersey, Feb. 1954.*

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nic described above in the operation of their well known cerebrolaundromats. From brain watching to brain washing may be but a single step. *Editorial, Brain Watcher's Manual. New England J. Med., Mar. 11, 1954.*

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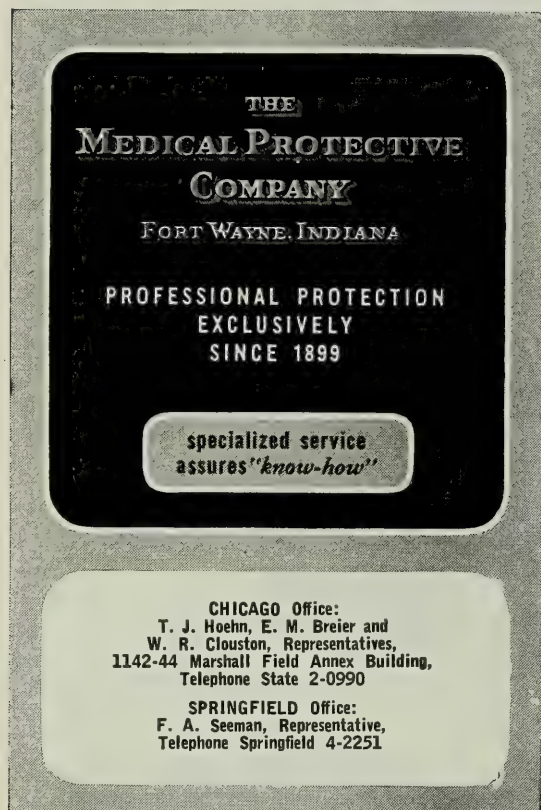
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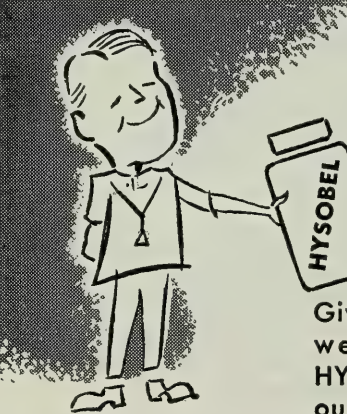
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1. Rogers, H. L.: Ann. Allergy 12:266 (May-June) 1954.

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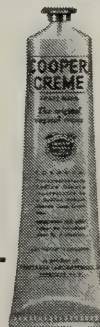
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**Official Journal of the Illinois State Medical Society**

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**Vol. 106, No. 6**

**December, 1954**

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## **The Meaning of Skin Tests in Allergy**

**Max Samter, M.D.  
Chicago**

If one had to select a diagnostic procedure representative of the practice of allergy, skin tests would be the logical choice. The skin tests which I am about to discuss are those of the immediate type—scratch tests or intradermal tests, which are used in the diagnosis of common allergic disorders; my remarks do not apply to the delayed type of sensitization.

Skin tests have enhanced our understanding of the relationship between sensitization and clinical symptoms of the allergic individual. If used as a primary diagnostic tool, on the other hand, and as a sole basis for treatment, skin tests have been responsible for many therapeutic failures.

A re-evaluation of their clinical significance seems to be mandatory.

The rationale of skin tests is deceptively simple. An allergic individual exposed to an "allergen" responds to such exposure with the formation of specific antibodies. After release from the site of formation, the antibodies are fixed in selected tissues; in man—predominantly—in the respiratory tract and in the skin. After fixation, exposure of the tissue to the specific allergen will produce an antigen-antibody union. Enzyme changes which accompany this reaction change histamine from an inactive into an active compound, which then produces the majority of the clinical manifestations.

The role of skin tests in allergy is based upon the assumption that antibodies are distributed to, and fixed in, different tissues, the so-called "shock tissues", in a fairly uniform manner; that, in other words, an individual who carries antibodies in the respiratory mucous membrane carries the same type of antibodies in the skin. This assumption is only partially correct: it is possible to carry antibodies in one "shock tissue" and not in another. Clinically, this accounts for the first of the two major fallacies in the interpretation of skin tests—the fallacy of the negative skin reaction, which holds that certain symptoms are of non-allergic origin if the skin of the patient fails to respond with wheal and flare to the introduction of the suspected allergen.

The most common respiratory allergies—seasonal hay fever and bronchial asthma—show a satisfactory correlation between positive skin tests and clinical symptoms. The majority of patients who are sensitive to pollen of trees, grasses and ragweed, or to spores of molds, have positive skin tests to the respective allergens. In allergies to environmental inhalants the percentage decreases sharply—in allergies to food the correlation is practically non-existent; it is, for instance impossible to detect a sensitivity to strawberries by testing patients with strawberry extracts. The reason for this discrepancy is not yet clear. In sensitivity to ingested allergens, the lack of correlation might not be due to the uneven distribution of antibodies, but to the fact that the methods of extracting which we employ might destroy some

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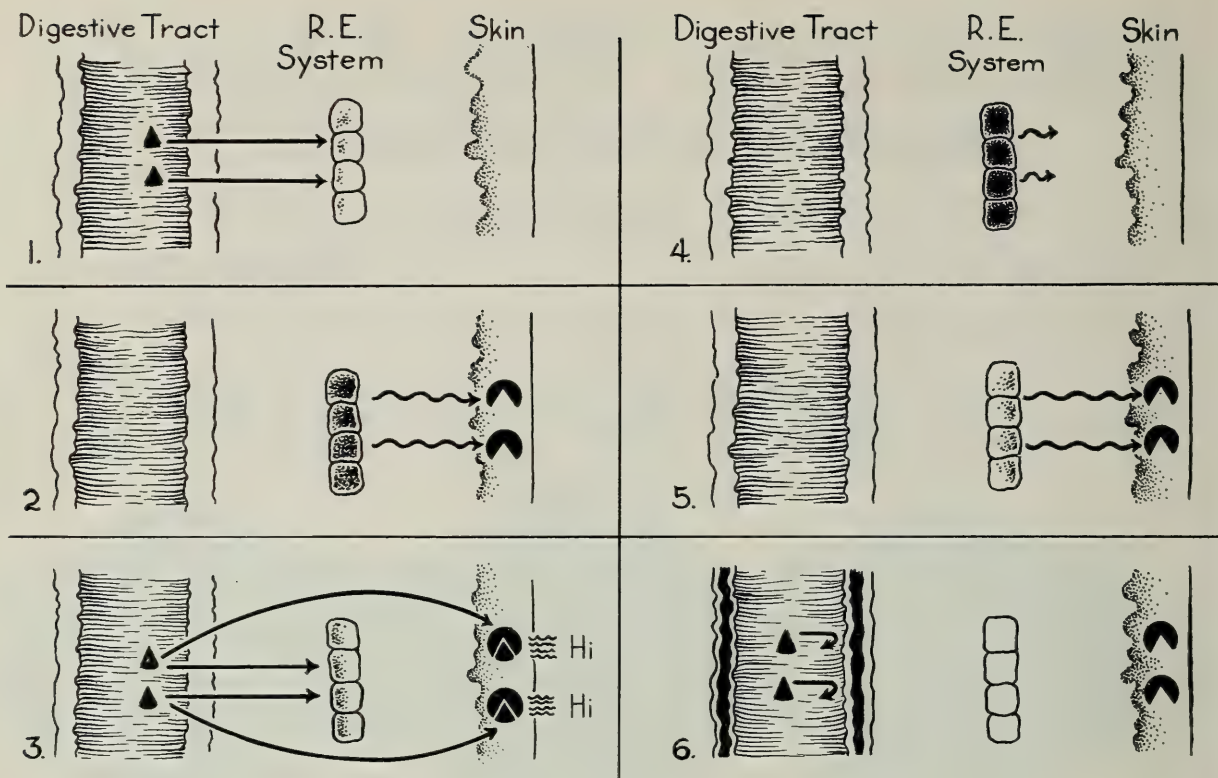


Figure 1. The role of gastrointestinal barrier, reticulo-endothelial cells and skin in the cycle which produces positive skin reactions — a working hypothesis.

of the characteristics of the allergen; that, in other words, we test with inadequate testing material. A study of the reasons for the absence of skin reactions to foods in established food allergy must be, and is, part of current research in allergy; but it is our concern to acknowledge this absence as part of our diagnostic difficulties.

In concluding the discussion of the fallacy of the negative skin tests, one might point out that the patient who carries a large number of antibodies in the respiratory tract and none in the skin is in danger when subjected to skin testing. It has been stated in fact that a positive skin test is a protective reaction. The local edema caused by histamine dilutes the antigen; the tissue pressure retards its absorption. In the absence of antibodies in the skin, absorption will be rapid; consequently, the patient is bound to develop systemic reactions.

The fallacy of the negative skin test is more apparent in childhood, particularly at an age at which the child shifts from a sensitivity to food to a sensitivity to inhalants. It is no uncommon experience to examine children who present symptoms after exposure to these aller-

gens—it is our experience that most of these children develop positive skin tests in later years.

The major source of grief in the interpretation of skin tests in allergy is not caused by the absence of skin reactions in the presence of clinical symptoms, but by the fallacy of positive skin tests. Positive skin reactions mean that an individual carries antibodies to a specific substance in his skin: this, however, is the only conclusion which is permissible. The burden of proof that the positive skin test has a clinical meaning rests with the physician: unless symptoms occur after controlled exposure, one must keep an open mind about their diagnostic significance.

In order to emphasize the fallacy of the positive skin test, it might be well to re-examine its physiological foundation. While the mechanism by which sensitization to common allergens takes place is not completely understood, it is rather certain that a number of pre-requisites must be fulfilled at the onset of the disease. Of these, the most important is the penetration of the mucous membrane by the allergen: the patient will not become sensitive unless anti-

genic material has passed through either the respiratory or the gastrointestinal mucous membrane. If skin sensitivity to egg develops in young children, for instance, it is reasonable to assume that undenatured egg protein has been ingested and has reached the site of antibody formation, probably the reticulo-endothelial system (Figure I, 1). After antibodies have been formed they are fixed in the skin (Figure I, 2). Re-ingestion of egg after fixation of antibodies will (a) produce an antigen-antibody reaction in the skin, with or without clinical manifestations, and (b) restimulate the reticulo-endothelial system to additional production of antibodies (Figure I, 3). After temporary neutralization (Figure I, 4) antibodies in the skin will be replenished (Figure I, 5)—the cycle is complete.

On the basis of clinical evidence, we suspect that during the growth of a child the permeability of the gastrointestinal tract may be altered, so that it becomes impermeable for the allergenic fraction of egg and other food proteins. If so, the child will be able to eat egg with impunity: he has lost his clinical allergy to eggs. In this instance, the last crop of antibodies which have been delivered to the skin will never be neutralized; in fact, they are able to remain in the skin for many years (Figure I, 6).

The persistence of antibodies in the skin is an intriguing phenomenon because the turnover of human protein, measured with radioactive isotopes, is known to be rapid. The time-honored statement that "the skin has a memory" is another way of saying that antibodies remain in the skin for an unexpected length of time. If the allergen is introduced into the skin by scratch or intradermal test, the child will give a positive skin reaction. It is our firm belief that wheal and flare in this instance does not indicate that the child must be clinically sensitive to egg at the time of the test.

The fallacy of the positive skin test is responsible for a considerably larger number of incorrect diagnoses in allergy than the fallacy of the negative skin test. Most physicians prefer not to perform their own skin tests, which require the maintenance of perishable material and rather elaborate equipment. In many cases which have come to our attention patients, particularly

children, have been sent to laboratories which specialize in the performance of skin tests: this is an acceptable procedure if interpretation and subsequent treatment are left to the referring physician. One of the representative laboratories in this area, however, goes one step further: it not only applies the tests, but at the end of the examination issues a comprehensive booklet, suggesting that the patient avoid inhalants and foods which have produced positive skin reactions. We have seen a sufficient number of children on unnecessary—and deficient—diets to state that this practice disregards the progress which diagnosis and therapy in allergy have made during the past decade. The technique is particularly pernicious if it pertains to foods because once a patient has been told that he is allergic to food he will correlate some of his functional responses with the foods that he has eaten. All people eat. Most people suffer occasionally from headaches, indigestion, fatigue. Once these two facts have been linked, it is difficult indeed to separate them. In fact, if one must test patients to foods, it is better not to inform them of the nature of any positive tests until a subsequent day by day diary has confirmed their clinical relevancy.

The recognition that one might be misled rather than directed by skin tests has restored the interview of the patient to its proper place in the diagnosis of allergy. The midwestern patient who suffers from rhinitis and bronchial asthma from mid-August to the end of September may or may not carry antibodies to ragweed in his skin. His history, on the other hand, suggests clearly that his respiratory mucous membranes are sensitive to ragweed. A patient who responds to the ingestion of lobster with giant hives is allergic to lobster; and a negative skin test will not change the diagnosis; but the same patient might also know that he can eat tomatoes even if tomatoes have been implicated by strongly positive skin reactions.

Several years ago we conducted an experiment in the Allergy Clinic of the University of Illinois Research and Educational Hospitals. Fifty patients ill with urticaria, hay fever, and bronchial asthma, were admitted and tested with seasonal and environmental inhalants and with a large series of extracts of representative foods. No history was taken; an attempt was made to

establish an etiologic diagnosis exclusively on the basis of skin tests. A subsequent group of fifty patients with comparable distribution of symptoms was referred to the attending staff for diagnosis without skin tests — an attempt was made to establish an etiologic diagnosis on the basis of interviews. With this procedure, an approximate diagnosis was made in less than 10 percent of the patients of the first group, an adequate diagnosis in almost 70 percent of the patients of the second group. The figures, which so strongly favor the history as a primary diagnostic tool in the type of allergic conditions under investigation, speak for themselves.

If the history of patients suggests the presence of a well defined seasonal allergy, one would on statistical grounds, have reason to be skeptical if one's impression were not confirmed by a positive skin test to the suspected allergens. If a patient is unable to furnish an adequate history or if a multiplicity of allergens make it impos-

sible to establish the relative clinical significance of each, skin tests might provide clues which will elucidate the etiology of the allergic disease. Skin tests which are carried out with an awareness of their limitations are indeed a valuable adjunct in the diagnosis of allergic conditions. They have come to be held in disrepute by many practicing physicians because their validity has been jeopardized by uncritical interpretation — there has been a great deal of disappointed hope because they do not represent, as was once assumed, a simple device for obtaining definite information about the etiology of indefinite conditions. We are confident, however, that a conservative attitude which integrates skin tests into the wider horizon of the allergic survey will not only safeguard their status as an important, if secondary, diagnostic procedure, but add to their usefulness in the control of the increasing problem of the control of diseases of sensitization. 1653 W. Polk St.

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## CONCENTRATE ON MIDDLE-AGE

A disintegrated old age has its roots, mentally and physically, in a mismanaged middle-age. Middle-age is the period in which the chronic degenerative diseases have their hidden onset. Even more important, middle-age is the time of intellectual and emotional shrinkage and deterioration, of a steadily narrowing horizon, of resignation and limitation. If anything, old age—if not unduly endangered by disease—is a time of recuperation, of the powerful stimulation of early wishes and wants which have long been forgotten at the assembly line of middle-age. This genuine, creative flare-up of vitality in many old people frequently breaks through the rigid crust of middle-life and is a phenomenon which should be seriously considered in work with older people. *Martin Gumpert, M. D., Geriatrics—A Social Problem. J. M. Soc. New Jersey, Feb, 1954.*

## THE ALCOHOLIC

Constructive medicine, by thorough periodic inventories, seeks to determine the situational state prior to the onset of psychosomatic disorders. These same principles of action can well be applied to finding the problem drinker. The great difference is that the problem drinker, unlike the health-conscious employee or the man with pain or cough, does not seek medical aid. All rational people seek early aid when disease strikes or potential illness threatens. The problem drinker, on the other hand, because he uses alcohol as an escape mechanism, invariably does everything possible to avoid detection by those who might threaten his means of escape. Because of the stigma and penalties, those close to the alcoholic are prone to aid him in avoiding this detection. *Robert Collier Page, M. D., Alcoholism And Industrial Health. Indust. Med. April 1954.*

# Surgical Diseases of the Temporomandibular Joint

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The temporomandibular joint is subject to injuries and diseases common to other joints, as well as certain conditions peculiar to it alone. The literature on these disturbances is extensive but there is a considerable dearth of material on the actual care of this joint.

Recent literature reveals that the technic of treatment in the reports of many decades ago, has not been substantially negated nor materially improved upon. Many of its features are still employed as standard procedure. Our purpose is to describe the diseases and injuries of the temporomandibular articulation with suggestions for their care and definitive treatment.

The temporomandibular joint is a diathrosis with two synovial cavities separated by a firm interarticular disc of fibrocartilage. The disc is an oval plate interposed between the articular cartilage of the glenoid fossa of the temporal bone and that of the condyle of the mandible. It is thinner posteriorly and thicker at the center. It is never perforated except by disease or injury. The superior surface of the cartilage is concavo-convex from before backwards, in adaptation to the convexity of the articular tubercle and the concavity of the glenoid fossa. Its inferior surface is concave and fits upon the condyle of the mandible.

A normal condyle is necessary for normal development, strength, stability and mobility of the mandible and temporomandibular joint. Yet, according to Blair<sup>1</sup> neither condyle is essential to normal function. The lower jaw is hung in such a muscular balance that both condyles can be removed, and where desired, the jaw can be moved forward without seriously crippling the function. Restoration of this joint, by simple excision of sufficient bone, with or without effort to



Figure 1. The Anatomy of the Temporomandibular Joint. Courtesy of Lea & Febiger, "Gray's Anatomy."

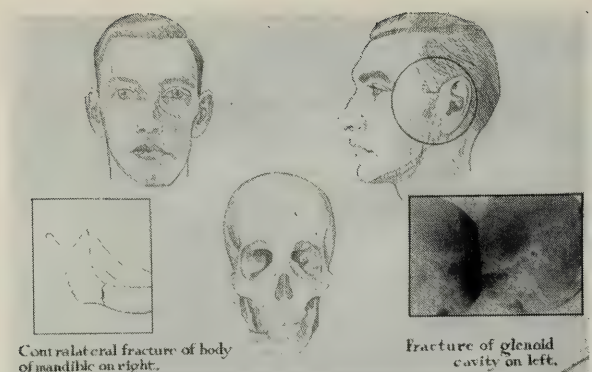
furnish a substitute for the necessary joint surface, results in almost universal success.

## DISLOCATIONS

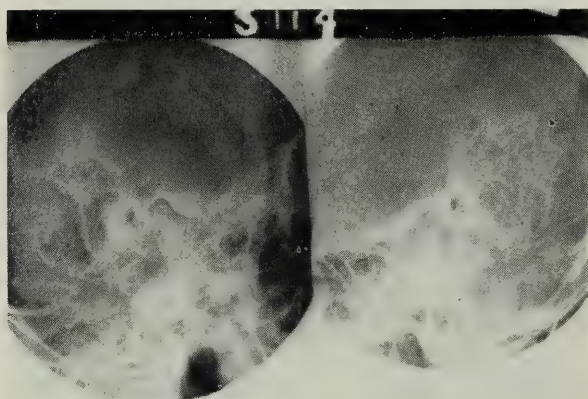
Forward dislocations of the temporomandibular articulation may result from muscular action and/or trauma during a fit of laughter, yawning, taking too large a bite of food, convulsions, vomiting and forcing too large a body into the mouth during anesthesia. The mechanism of the dislocation is a slipping of the condyle over the articular tubercle into the zygomatic fossa, with the interarticular disc following the condyle, as the external pterygoid muscle is attached to both. Depending upon the etiology, the dislocation is usually bilateral; however, it may be unilateral. The mouth is held open, the mandible is fixed by spasm of the muscles surrounding the joint, and speech and deglutition are impaired with saliva dribbling over the lower lip. Palpation will demonstrate a hollow in front of the tragus. The coronoid process may be felt by passing a finger into the mouth immediately below the zygoma.

As a rule, reduction is easy and should be performed at the earliest possible moment. By depressing the condyle below the level of the articular tubercle, the contraction of the pos-

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**Figure 2. Drawing to show condyle forced into the cranial cavity, with contralateral fracture on the opposite side.**



**Figure 3. Roentgen ray of condyle forced into the cranial cavity.**

terior temporal muscle fibers, the masseter and internal pterygoid muscles, pull it back into the glenoid cavity. For this procedure to reduce the dislocation, the surgeon protects his thumbs with a towel to prevent injury to them. He then faces the patient, who is seated, and downward pressure is exerted by the thumbs on the lower molar teeth until the condyles slip backward over the articular tubercle. If this procedure fails, reduction can be obtained under general anesthesia.

Periarticular structures are not weakened as a rule, therefore, recurrent dislocations are rare. However, patients are seen occasionally with a lax joint following repeated dislocations. These are reduced quite easily and many times by the patients themselves.

Von Stapelmohr<sup>2</sup> was unable to find a relationship between the usually ascribed abnormalities and habitual dislocation, because investigation at the time of operation failed to reveal

deficient development of the articular tubercle, lack of depth of the articular cavity, malformation of condylar head or relaxation of the ligaments. The writer concurs in these findings.

*Upward Dislocation.*—Upward dislocation is associated with fracture of the glenoid cavity. This type of accident has been generally regarded as fatal. Such a case was reported by LeFever.<sup>3</sup> However, the following case was observed by the present author which offers contradictory evidence to this theory.

R. E., a male aged 33, received a blow on the angle of the left mandible producing an upward displacement of the condyle in the middle fossa of the skull; a contralateral fracture of the body in the mandible on the right. The patient was edentulous. Reduction was accomplished by using his dental plate for fixation of the mandible to the maxilla. Figures 2 and 3. Initial physical findings in this case were that of a seventh nerve. However, on reduction of the fracture the apparent paralysis disappeared. Recovery was complete. A search of the literature failed to reveal a case with similar results.

*Outward Dislocation.*—A case of outward displacement was reported by Roberts<sup>4</sup> in which the body of the mandible was fractured in front of the angle and the condyle was to the outer side and above the zygoma. This accident is unusual and no similar case has been reported.

*Backward Dislocation.*—Backward dislocation is always associated with fracture of the tympanic plate and separation of the cartilage of the external acoustic meatus. Treatment is directed toward bringing the mandible forward and retaining it in its proper location by interdental fixation for a period of approximately three weeks. The external auditory canal may require remoulding to prevent obstruction.

*Unreduced Dislocation.*—This type of dislocation results in a false joint, with the patient gradually learning to talk, eat and swallow; the dislocation remaining obvious. When this occurs, the muscles of mastication become fibrosed and reduction impossible. Excision of the condyle is indicated here to restore normal jaw movements.

#### DISPLACEMENT OF THE MANDIBULAR CARTILAGE

This is a rare accident, probably due to the shape and attachments of the meniscus, divided by a fibrocartilaginous disc into two cavities, each

provided with a distinct synovial membrane as in Figure 1. The circumference of the disc is adherent to the capsular ligament and anteriorly affords partial insertion of the external pterygoid muscle. These two definite cavities in this joint result in two types of movement. These are complex gliding movements whereby the interarticular disc and the condyle move together as one with the temporal bone, taking place in the upper synovial cavity. Further, a rotation between the disc and the condyle occurs in the lower synovial cavity. These two movements probably take place independently of one another.

Displacement of the mandibular meniscus is due to some sudden or irregular contraction of the external pterygoid muscle. The mandibular cartilage always remains intact. Displacement of the cartilage may be caused by violent cough, sneeze or yawn, the external pterygoid muscle contracting during rapid closing of the mouth, drawing the cartilaginous disc obliquely forward and inward. Occasionally displacement may result from a blow on the jaw when the mouth is open, the trauma not being of sufficient force to cause dislocation of the condyle over the articular tubercle of the temporal bone. The posterior thinned out portion of the meniscus becomes detached from the capsule. As the mouth closes by elevation of the jaw, the disc of cartilage becomes severely crushed between the condyle and the temporal bone.

Symptoms caused by such displacement are characteristic. The patient experiences sudden acute pain in the joint which may be referred to the pinna or the skin above the pinna. This referred pain is due to the auriculotemporal nerve, not only supplying the joint, but also giving off sensory branches which supply the upper part of the pinna and the skin above it. All attempts to close the mouth are painful and the patient will complain of something sticking in front of the jaw which prevents him from shutting the mouth. Excessive salivation is often a marked feature, but in old standing cases or those in which the meniscus is very mobile because of repeated displacement, it is often so slight as to cause the patient no annoyance. Mastication is attended with considerable difficulty, as even slight chewing causes acute pain. This, however, becomes less marked in a day or so probably because of a definite synovitis set

up with the occurrence of primary displacement. This synovitis causes the capsule of the joint to become very tense and this in itself will account for the pain when movement occurs in the joint. When the synovitis becomes chronic, pain is much less marked and greater mobility of the meniscus is possible. Often the patient suffers from continual recurring displacement. This cannot be regarded as acutely painful but very distressing, since the meniscus slips in and out of position causing a definite audible snap. In a few patients, this snap is a source of great annoyance, especially at meal time, making them reticent about eating in public for fear of attracting attention.

As regards treatment, reduction is much more likely to succeed and be permanent if performed when the meniscus is first displaced. In old standing cases the effect of the reduction is only temporary. The best method of reduction is to maintain continual pressure behind the condyle of the jaw while the mouth is open. By this means the convex upper part of the condyle will be inserted into the concave lower surface of the meniscus. After a few minutes of this continued pressure, the mouth is closed by slowly elevating the jaw. Frequently the meniscus slips back with an audible click, while at times nothing is noticed at all, but the patient states that the obstruction in the joint has disappeared. Several attempts are often necessary before reduction is complete.

#### "SNAPPING JAW"

This disturbance per se, is not an entity, but a symptom of various diseases of the jaw. The same changes take place in the jaw as occur in a large joint, e.g., the knee, when there is a recurrent displacement of the medial meniscus. Periarticular tissues, capsule, ligaments and muscles become repeatedly stretched and eventually relax. This allows the meniscus to be displaced whenever the mouth is widely opened. In these chronic cases no treatment, with the exception of excision, is of any value. Fortunately, most of these patients are quite content to put up with the slight pain and inconvenience caused by the repeated "snapping" of the meniscus. However, an occasional patient demands relief from the chronic pain and continual "snapping," described as unbearable.

Age and sex play no important role in this

condition and its occurrence is both unilateral and bilateral. The snapping occurs in two forms: (1) during the opening of the mouth (intermediate), and (2) at the termination of the opening movement (terminal snapping). Intermediary snapping is usually the result of arthritis of the joint, analogous to that found in other joints. Terminal snapping is usually the result of habitual subluxation of the joint.

When palliative measures; such as, rest, application of heat, and restriction of motion fail to bring relief, recourse must be had to surgical methods directed toward removal of the cause, e.g., treatment of the habitual dislocation or removal of the abnormal meniscus.

The internal pterygoid muscles may act to displace the loosely applied cartilage so that the thick central ridge lies obliquely instead of transversely, the cartilage assuming the role of a foreign body in the joint.

#### SYNOVITIS AND ARTHRITIS OF THE TEMPOROMANDIBULAR JOINT

These diseases are uncommon, but may be seen during an attack of acute rheumatism. There is some swelling of the articular and periarticular structures. Due to synovial effusion, movements of the joints are painful and the patient is often afraid to speak or open the mouth. As a rule, complete resolution takes place, but sometimes intrarticular adhesions form which eventually lead to impairment of movement.

Serous synovitis occasionally occurs in the joints but leaves no aftermath. Chronic synovitis is a rare condition, but may be seen in cases of recurrent subluxation of the joint.

#### ACUTE ARTHRITIS

Acute arthritis of the temporomandibular articulation may be pyemic in origin when it is a sequela or one of the exanthemas, or it may be secondary to gonorrhea, acute parotitis or acute otitis media. Postscarlatinal otitis media is quite likely to be the cause of direct extension of inflammation through the tympanic plate into the joint. In children it may be difficult to diagnose the condition when acute otitis is present, and an abscess formation which rapidly points and bursts externally, may be the first indication that the joint is infected. It is important that such an abscess should be incised and drained as soon as it is diagnosed. Acute arthritis is invariably followed by ankylosis, which requires excision of the condyle at a later

date when all signs of inflammation have subsided.

#### CHRONIC ARTHRITIS

Osteoarthritis is by no means rare in the temporomandibular joint, although it is often overlooked as a cause of pain in the joint. With modern methods of radiology the condition can be seen quite easily in roentgenogram. It may be symmetrical, and is characterized by considerable enlargement of the condyle of the jaw which causes it to bulge laterally so that it can be felt in front of the tragus of the ear. Movements of the joint are painful and limited, and crepitus can nearly always be elicited. If the condition is bilateral, the lower jaw appears to be pushed forward, rendering the chin quite prominent. If, however, it is unilateral, the jaw becomes deflected to the sound side.

Loose bodies may form in some cases and may cause "locking" of the joint. In others there is extensive lipping of the periphery of the condylar cartilage, proliferation of the synovial villi, and "lipoma arborescens" may be in evidence. As the disease progresses the interarticular cartilage may disappear completely. The glenoid cavity, as it enlarges, may assume a flattened outline, so that there may even be a partial dislocation. If only fair, or marked limitation of movement is complained of, the only satisfactory treatment is excision of the condyle. Other forms of treatment have been found useless and a waste of time.

#### TUBERCULOUS ARTHRITIS

It is often difficult to determine whether tuberculous disease in the joint has arisen in the bone or in the synovial membrane. The affection itself is rare and only seen when the disease is fairly well advanced. It runs the usual course of any tuberculous joint affection and ends in caries of the condyle. Secondary infection may occur, leading to ankylosis. Tuberculous arthritis is very chronic and has been mistaken for osteoarthritis on more than one occasion, the true diagnosis being made only when excision of the condyle was performed and the bone subjected to microscopic examination. Neuropathic arthritis of the temporomandibular joint is a very rare entity.

#### TRISMUS

Immobility or closure of the jaw may be the result of a great variety of conditions. Fibrous

or osseous ankylosis may result from any acute suppurative condition: old standing dislocations, where a false joint has been formed in front of the glenoid cavity; chronic cases of osteoarthritis where the amount of osteoarthritic outgrowth is excessive; in cases of fracture of the neck of the condyle with excessive callus formation; rarely in cases of cyst or tumor formation in the head or condylar neck, and in cicatricial contraction of the surrounding soft structures, as from burns and scalds, lupus, noma, and scars resulting from operations or the application of radium in the pterygoid region. Gummatous infiltration of the masseter muscle leading to fibrosis occasionally occurs. Very rarely myositis ossificans has been the cause. Spasm of the muscles of the jaw due to reflex irritation or impacted third molar tooth has occurred. Occasional spasm may be hysterical in nature, and is one of the early signs of tetanus. The pain and swelling of the more common local inflammatory conditions; such as, lymphadenitis, acute tonsillitis, mumps, parotid abscess, and acute alveolar periostitis, often render opening the mouth impossible. Any malignant growth of the face or cheek may seriously impair the mobility of the jaw. Likewise, extensive actinomycosis of the skin covering the jaw, and an acute necrosis of mandible with sinus formation may lead to extensive fibrosis which will eventually cause fixation of the jaw.

#### TREATMENT

Treatment of the different varieties of fixation of the temporomandibular joint necessarily vary according to the causative conditions. Bony ankylosis often presents a difficult problem, because the surgeon is working in a limited space and any attempt to remove the neck or head of the condyle by means of a chisel or osteotome may result in fracture of the middle ear, injury to the facial nerve, undue hemorrhage from the internal carotid artery, et cetera.

Blair,<sup>5</sup> and Murphy and Kreuscher,<sup>6</sup> did much to standardize the operation for ankylosis of the jaw. Murphy stated that results of the operation were the most gratifying in bone and joint surgery and that the procedure was one of the easiest to perform.

The author employs the following operation, as developed and used by Blair.

*Excision of The Condyle of The Mandible And Arthroplasty.*—The hair is shaved for a distance of two inches above the level of the ear, and posterior to a line dropped through the mastoid process. The remaining hair is drawn upward away from the field of operation. The skin is then prepared and drapes applied, with the face exposed to the operator, making the distribution of the facial nerve visible at all times. The initial incision is made beginning 2.5 cm. directly in front of the upper attachment of the ear. From this point the incision curves sharply upward and backward, thence downward immediately in front of the ear to a point in front of the lobe. This incision is carried through the skin, and a skin flap is dissected downward, taking with it only enough subcutaneous tissue to insure nourishment. The superficial fascia is incised down to the temporal and parotid fascia and zygoma, along the line and to the extent of the skin incision. The flap of fascia will be used in making the new joint. Care is exercised at this point not to cut the temporal branch of the temporal facial division of the facial nerve, as this supplies the anterior belly of the epicranial muscle. The flap of fascia will include the superficial temporal artery and vein to insure viability. The masseter muscle and fascia are cut free from the posterior portion of the zygoma and retracted downward and forward, exposing the temporomandibular joint. Examination will demonstrate the pathology present, which may be dense fibrous adhesions, a bony overgrowth, or a true ankylosis. The condyle is then resected by means of the gigli saw, or chisel and rongeur, keeping in mind that the internal maxillary artery, and the inferior alveolar nerve lie medially to the bone. The sigmoid notch and coronoid are involved frequently in true ankylosis. The ankylosis being freed, a dilator is inserted into the mouth and an attempt made to open it. Failure to open indicates that the opposite side is undoubtedly involved and the same procedure is repeated here. The flap of fascia is sutured deep in the wound to any available soft tissue, followed by skin closure.

#### COMMENT

Two primary factors prompted the author to this discussion of the care of the diseased or traumatized temporomandibular joint. One was

the observation, both in private and military practice, that satisfactory and definitive results in arthritis and/or ankylosis of the jaw were lacking when conservative methods of treatment were attempted first, or adhered to. It is the writer's opinion that these methods are a waste of time for both patient and physician. Surgical intervention, when no contraindication exists should be the treatment of choice.

In conditions in which excision of the condyle is indicated, the results are, as a rule, immediate. In arthroplasty, end results depend largely on the patients themselves. The persevering ones obtain excellent results, while the nervous patients who will not try to move their jaws, often complain that the operation has been a failure; that they are little benefited by the surgical intervention. The surgeon should try to screen and to assist every patient before undertaking the operation, in order to be able to gauge the potential reaction in each patient. Some patients should never be operated upon, as failure is assured by their behavior prior to surgery.

The most difficult cases to relieve or cure are those in which there is much cicatricial contraction around the joint. Division or excision of the adhesions is useless, as during healing, fresh adhesions form and the condition is unrelieved.

The second factor which led the author to this discussion, was the observation and conclusion, after a study of the subject of "Snapping Jaw," that this disturbance per se is not an

entity but rather a symptom of some underlying pathologic condition of the jaw and should be subjected to diagnostic study and treated accordingly.

#### SUMMARY

1. The temporomandibular joint and diseases and injuries to which it is prone are described and discussed.

2. Modern methods of care and treatment of this articulation are suggested.

3. Lack of definitive results from conservative treatment of arthritis and ankylosis of the temporomandibular joint is pointed out, and immediate surgical intervention, whenever possible, is emphasized.

4. Two surgical procedures: condylectomy and arthroplasty, are described.

5. "Snapping Jaw" is discussed, not as a primary disease, but as a symptom of various diseases of the jaw.

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# Xanthomatoses

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The subject of xanthomatoses is still in a stage in which only the classification and recognition of syndromes is possible. The basic mechanisms of these diseases is unknown and no means are available to fundamentally alter their course. It is greatly due to the efforts of S. Thannhauser that a clearer knowledge of the clinical entities is available and I shall follow and slightly modify his description in discussing the problem.

In general, xanthomatoses are diseases, in which large amounts of cholesterol are deposited within histiocytes, which in turn accumulate in tumor like formations in various organs. They are usually described under the heading of "storage diseases" and discussed together with conditions in which other lipid material is stored producing analogous pictures (Gaucher, Pick-Niemann's disease, etc.). There are two main types of xanthomatoses: such with and without elevation of the serum cholesterol. The *hypercholesterolemic forms* are the more commonly encountered and termed "*Primary, essential hypercholesterolemia with eruptive xanthomatosis*." They manifest themselves by tuberous formations in the skin of yellowish nodes mostly located on the extensor surfaces of the extremities but also upon the trunk and the scalp. In some cases the skin is free from such deposits, but large tumor like accumulation is

found surrounding the tendons mostly on the lower extremities and fingers. This type, called tendon xanthomatosis, is not uncommon. In all cases more or less extensive atheromatosis of the arteries is found and if vessels are involved which supply vital organs, death may ensue directly due to such deposits. Many patients with this disease die of coronary occlusion. Xanthomatosis of the heart valves has been observed repeatedly. The liver is usually large in such patients and the enlargement due to fatty infiltration. Only occasional nests of xanthoma cells are found in this organ. The true xanthomatous biliary cirrhosis, characterized by jaundice, hypercholesterolemia, liver cirrhosis and xanthomatosis of the skin was formerly thought to belong in category of primary xanthomatosis. Careful histological studies on liver biopsy specimens and autopsy material have revealed however, that this is a primary liver disease with secondary hypercholesterolemia and not a primary storage disease.

One form of xanthomatosis occurs in association with mild diabetes. It cannot be regarded as secondary to a disturbance of lipid metabolism in diabetes, because the majority of cases of even severe diabetes do not exhibit this lesion. Most likely the xanthomatosis and the diabetes are linked genetically and manifest themselves together in one or more offsprings of the same family.

A considerable literature has accumulated in relation to xanthomatosis accompanying chronic pancreatitis. This rather puzzling association has raised the question which one of these lesions is to be regarded as the primary one. It is usually referred to as a separate entity under the heading of a "secondary eruptive xanthomatosis" implying that chronic pancreatitis produces a hypercholesterolemia and secondary xanthomatosis. A careful survey of cases of xanthomatosis reveals however, frequently the presence of obscure abdominal pain in the upper

epigastrium. There are cases on record which have been explored surgically and nothing but increased amounts of intraperitoneal fluid was found. In others, chronic pancreatitis was demonstrated. In one of the patients, who was under observation at autopsy, an extensive atheromatosis of the pancreatic arteries was found. The possibility must be thought of, therefore, that the hypercholesterolemia through mechanisms unknown, possibly by involvement of the pancreatic vessels, produces pancreatic changes. If so, chronic pancreatitis might be one of the manifestations of idiopathic xanthomatosis.

It was stated that all cases of essential xanthomatosis exhibit a considerable elevation of the plasma cholesterol but the serum is clear, because the fatty acid content and the neutral fats are normal. If the latter two are increased, the appearance of the serum is milky. Cases with milky serum are then classified in a separate category. In our experience cases of definite xanthomatosis have at times a milky serum and the fat content is elevated. I should, therefore, question the necessity of separating these two types of hypercholesterolemia. In connection with this question, it appears doubtful whether the Buerger-Gruetz syndrome should be separated from the disease group under discussion. This is an entity which occurs in children and is characterized by the presence of a milky serum, a xanthomatous eruption on the skin, abdominal pain, and hepatomegaly. It was stated originally that the serum cholesterol is normal and only the neutral fat and fatty acids are increased. A careful survey of the reported cases reveals however, that hypercholesterolemia is present in many cases.

I should like now to discuss briefly the pathogenesis of these diseases. It appears obvious that the primary cause of the clinical manifestations is the elevated serum cholesterol level. Cholesterol is synthesized from acetic acid in many organs, transported in the plasma, partly excreted through the gastro-intestinal tract, and partly through the bile. It is metabolized in the liver and probably other organs. Cholesterol is utilized by the adrenal cortex for the manufacture of steroid hormones and possibly for the production of sex hormones. The question, whether bile acids are produced from cholesterol is controversial but the excretion of cholesterol

by the bile is intimately related to the excretion of cholic acid and stands under the influence of thyroid hormone. In hyperthyroidism more cholesterol is lost with the bile and the blood level is low and the opposite is the case in hypothyroidism. The liver and possibly the small intestine, esterify the free cholesterol and in normals approximately 70% of the substance circulates as esters. The elevation of the serum cholesterol may be therefore, due to over production or under utilization of cholesterol or to a disturbance of the transport mechanism, by which the plasma is unable to unload itself of the excess lipid. The latter is the most likely explanation because neither over production nor under utilization was ever demonstrated in the cases which have been studied. Cholesterol in the plasma is transported in a rather complicated physico-chemical state and number of substances are operating to maintain its stability. These processes are poorly understood, but heparin seems to have an effect on the equilibrium. So far, the factors leading to essential hypercholesterolemia are unknown although it is certain that they must be linked to genes because the disease has been proven to be familial.

In cases in which the hypercholesterolemia is secondary to another disease (e. g., hypothyroidism, nephrosis, biliary obstruction) xanthomata may be formed in the organs. These conditions are then labeled "secondary xanthomatoses".

The treatment of primary xanthomatoses has not been satisfactory. A low fat diet will temporarily reduce the lipid content in the plasma and cause a regression of the skin eruptions but the fundamental pathologic process will not be altered. Heparin cannot be used because it will reduce the lipemia only for a short period of time. Lipotropic substances are useless in the treatment of this disease.

The other major category of xanthomatoses is characterized by organ involvement with perfectly normal lipid values in the plasma. Investigations of the past few years have thrown an entirely new light upon this group of conditions, which cannot be classified any more as storage diseases. They are characterized by either extensive and general organ involvement with dissemi-

nation over nearly the entire body or by localization in one organ group. If the skin is involved, the xanthomata are smaller in size, brownish in color and occur mostly on the trunk and the axillae. The bones are quite frequently affected. If the location is in the skull, brain, and dura, and causes protrusion of the eyes and pressure upon the hypothalamus causing diabetes insipidus an entity, known as Hand Schuller Christian syndrome results. The lungs and heart muscles may also be involved. The fundamental lesion is a granuloma, the cause of which is unknown. Certain stages in the development of this granuloma can be differentiated such as a histiocytic proliferations stage, a true granuloma stage with numerous eosinophiles, the appearance of foam cells containing cholesterol and imitating true xanthomata and finally fibrosis. This lesion may be strictly confined to one bone area, then the term "eosinophilic granuloma" is applied. Some of the lesions respond favorably to x-ray therapy.

*Dr. Gilbert Kipnis* (Research Assistant in Medicine): Does one always have vessel involvement in essential hypercholesterolemia?

*Dr. Matthew Taubenhaus*: If one studies family members of patients with essential xanthomatosis, one frequently finds a considerable cholesterolemia without skin involvement. Vascular changes may be extensive and are clinically difficult to diagnose. I would say that vessel involvement is rather common.

*Dr. Robert L. Grissom* (Assistant Professor of Medicine): Would you explain the serum clearing effect of heparine?

*Dr. Taubenhaus*: I do not believe that this is possible at the present time. We have to assume that the complex stability of serum proteins, mucoproteins, and lipoproteins is influenced by a number of substances and heparine and possible the adrenal steroids may be their representatives. They seem to have an antagonistic effect upon the serum lipids.

*Dr. Adolph Rostenberg, Jr.*, (Professor of Dermatology): Wilkins has described hypercholesterolemia in xanthelasmatis.

*Dr. Taubenhaus*: Xanthelasmata are rather common and occur as grayish yellowish flat masses on the lids, rarely on the forehead and the neck. Definite family traits can be followed in this condition. It is true that some such pa-

tients have elevated plasma cholesterol values while others do not. There seems to be a peculiar local factor operating which is entirely unknown.

*Dr. Walter Wood* (Instructor in Medicine): What is your explanation for the high incidence of coronary occlusion in xanthomatosis?

*Dr. Taubenhaus*: I believe that this statement has to be re-evaluated after a more extensive statistical study.

*Dr. Wood*: What is the relationship between the hypercholesterolemia and the skin lesions?

*Dr. Taubenhaus*: Here again, the local skin factor has to be stressed, which has some relation to the ability of the tissue to dispose of excess cholesterol. We have no knowledge of these processes.

*Dr. William S. Hoffman* (Lecturer in Medicine): The classification falls down, because abnormal values may become normal. The plasma cholesterol is partly dissolved in lipids, partly circulating as lipoprotein and partly circulating in an unstable colloidal form, which is the one related to precipitation in the tissues.

*Dr. Taubenhaus*: This would place the emphasis upon the circulating medium — the plasma — as the determining factor. I would rather think that the tissue factor has to be taken into account.

*Dr. Grissom*: Would you please comment on the effect of estrogen on cholesterol?

*Dr. Taubenhaus*: Administration of estrogen to cholesterol fed chicks prevents arteriosclerosis in the coronary arteries and even causes regression of coronary atherosclerosis. The other arteries are not affected and the plasma cholesterol is the same as in the controls or even slightly higher. This again demonstrates the "local factor" I have been talking about.

*Dr. Ford K. Hick* (Professor of Medicine): In your discussion of dietary treatment, do you advocate a low calorie and low fat diet?

*Dr. Taubenhaus*: Yes.

*Dr. Thomas Benedek* (Assistant in Medicine): How long does it take for a low fat diet to cause a response?

*Dr. Taubenhaus*: Sometimes only weeks.

*Dr. Wood*: Should patients with familial histories of coronary sclerosis remove eggs, etc. from their diets?

*Dr. Taubenhaus*: I am afraid that the answer to this question would lead us to a field beyond the scope of this discussion.

# Intractable Heart Failure

James A. Walsh, M.D.  
Peoria

In the last two decades there have been added only a few new agents for the treatment of congestive heart failure. The most important of these are cation exchange resins, carbonic anhydrase inhibitor, antithyroid compounds, anticoagulants, and curative or palliative surgery in selected patients. However, there has been a more physiological approach to therapy as a result of new knowledge of the hemodynamics of the circulation, electrolyte and water metabolism, the role of the kidney in heart failure, and the re-discovery of the benefits of sodium restriction. The management of edema has become notable more successful. Consequently, the victim of heart disease can be offered more help than heretofore and the burden of the disorder can be made more bearable. Nevertheless, an occasional patient may become unresponsive to all combinations of therapy that can be devised, and considered to have refractory or intractable heart failure. It may then be necessary to accept the condition as irreversible and terminal, but such a decision should not be adopted until there has been a thorough appraisal of the problem in the light of present day knowledge of diagnosis, the effect of complicating factors, dislocations of electrolyte metabolism, and the favorable as well as the adverse effects of therapy.

The validity of the diagnosis of heart disease must first be established. Chronic pulmonary disease with or without cor pulmonale, cirrhosis of the liver, acute and chronic renal disease, generalized carcinomatosis, severe anemia, and any disorder accompanied by effusion cavities may simulate myocardial failure to the extent that the correct diagnosis is obscured and appropriate treatment is omitted. It is especially important that chronic pulmonary emphysema be recognized since overzealous treatment with opiates, sedatives, and concentrations of oxygen commonly used in heart disease may lead to a fatal carbon dioxide intoxication syndrome.

If it is established that heart disease is present and primarily responsible for the patient's illness, it is more urgent now than ever before that a correct etiological and anatomical diagnosis be made. There is a new and well-founded optimism about heart disease now that certain forms are reversible. Heart disease solely due to beri-beri, some of the anemias, and myxedema can be cured by proper therapy. If a syphilitic process has been overlooked, the patient is denied the benefits of antiluetic therapy. A silent myocardial infarction may be responsible for aggravation of symptoms. Hypertensive cardiovascular disease due to coarctation of the aorta, pheochromocytoma, and unilateral renal disease may be attacked surgically. Acquired and congenital vascular and cardiac defects may now be ameliorated or cured by surgery. Thus, the proper diagnosis and the initiation of proper treatment may indeed insure survival, or at least afford great relief and increase the span of productive existence.

An exhaustive search should be made for either a local or systemic disorder that may have precipitated heart failure or contributed to its resistance to treatment. Among such conditions are: bronchopulmonary infection, often afebrile, and manifest only by cough and mucopurulent sputum; an active myocarditis, often due to rheumatic fever, which may occur at any age; pulmonary infarction from emboli arising in peripheral veins or the heart cavities, suggested by the occurrence of unexpected episodes of dyspnea, cyanosis, fever, tachycardia, chest pain, hemoptysis, jaundice, and bloody pleural effusion; pyelonephritis; acute or chronic nephritis; obstructive uropathy; hyperthyroidism, especially the apathetic type, accompanied by paroxysmal or chronic atrial fibrillation with a ventricular rate uncontrolled by digitalis, and identified by an increase in the blood protein bound iodine level, or radioactive iodine uptake; avitaminosis, especially thiamin deficiency due to anorexia, diet restriction, or loss through diuresis; hypoproteinemia; an allergy with pulmonary mani-

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festations which may co-exist with heart disease; and mechanical embarrassment of the circulation produced by pericardial, pleural, or peritoneal effusions.

Every phase of the therapeutic program should be critically reviewed for errors of omission and commission. Since only digitalis and its glycosides are decidedly effective in increasing the efficiency of the myocardium and restoring normal circulation, they remain the mainstay of treatment. In recent years there has been an aggressive introduction of numerous glycosides resulting in a confusing diversity of dosage, and the incidence of inadequate therapy and also drug intoxication has increased. Insufficient digitalis denies the patient optimum treatment, and overdosage may insidiously aggravate the existing state of failure. Failure to recognize the symptoms and signs of digitalis poisoning may lead to continued overdosage with catastrophic results. There is no specific antidote for digitalis intoxication, although the administration of potassium chloride may be of value. Conversely, it is well to remember that a patient receiving chronic digitalis therapy may slowly become underdigitalized, and if such is suspected a cautious increase in dosage may be undertaken. If the condition of the patient is critical, the additional dose may be given intravenously. It is good judgement to learn to use competently only one product for oral administration, and one rapid acting glycoside for parenteral use. Patients with progressive failure in the presence of chronic atrial fibrillation may at times improve if the abnormal mechanism is converted to sinus rhythm. For this purpose quinidine is the drug of choice. If there is potential danger to this procedure it may be accepted as a calculated risk. The use of an anticoagulant prior to the attempted conversion may prevent an embolic accident.

Organic mercurial diuretics have been in use for 35 years and numerous satisfactory products are now available. Some have even advocated their use to the exclusion of digitalis. These compounds should not be used in the presence of acute renal disease or in chronic kidney disease with renal failure. Even in the presence of good renal function, over-enthusiastic use of mercurial diuretics, especially in conjunction with the low sodium diet, may worsen

the condition of the patient due to disturbances of electrolyte balance. Hence, one should with caution attempt to perpetuate a dry weight regimen by increasingly frequent large doses of mercury compounds. Some patients may be comfortable even in the presence of perceptible edema, and symptoms as well as signs should determine the frequency of injections. When an edematous patient no longer responds to a mercurial compound with an adequate diuresis, it should not be at once interpreted as evidence of mercury fastness. Instead, blood chemistry studies should be performed to determine the presence or absence of electrolyte imbalance. There may be a hypochloremic alkalosis manifest clinically by oliguria and chemically by a low blood chloride level, increased carbon dioxide combining power, and occasionally nitrogen retention. This state of imbalance is the result of chloride loss primarily through diuresis, is usually not serious, can be circumvented by the intermittent administration of ammonium chloride during mercurial diuresis, and corrected by the use of the same drug. Rarely the excessive use of ammonium chloride can produce a hyperchloremic acidosis with the resultant increased dyspnea being interpreted as evidence of more severe heart failure. The most serious form of electrolyte disturbance is known as the low salt syndrome. This is manifest chemically by a decreased blood sodium level, acidosis, and uremia, and clinically by resistant edema, oliguria which may progress to anuria, weakness, drowsiness, abdominal pain, nausea, vomiting, mental confusion, and terminally by vascular collapse. Treatment consists in the administration of hypertonic saline solution intravenously and water restriction. Theoretically, this should be successful, but as a rule despite correction of the blood changes, the outcome is fatal. If normal electrolyte balance is present and renal function is good, the diuretic effect of the mercury compound may be enhanced by the concurrent use of aminophyllin which inhibits tubular resorption of sodium, increases renal plasma flow and glomerular filtration, and increases cardiac output. Ascorbic acid, decholin, and pyridoxine have also been advocated to enhance the response to mercury. It should be remembered that effort, barbiturates, and opiates have an antidiuretic effect, and antidiuretic hormone

may be a factor in resistant edema. The newest diuretic available is the carbonic anhydrase inhibitor, released by the trade name diamox. Experience with this is as yet limited but it appears to be a valuable addition to the diuretic drugs, and is convenient in that it is administered orally. It has been observed that potassium loss occurs with the diuresis induced by this product and that hyperchloremic acidosis may also be produced.

The use of the low sodium diet has become a standard procedure in the therapy of cardiac edema. In intractable heart failure severe restriction of sodium may be required. Patients on such a diet may find it unpalatable despite the use of salt substitutes and one must watch caloric, protein, and vitamin intake. It is desirable to supplement the diet with a B complex product high in thiamin content. If hypoproteinemia is permitted to occur it is very difficult to correct and edema becomes more resistant to treatment. Low sodium, high protein food supplements may be added to increase protein intake. The patient on such a diet is not inclined to thirst and fluid intake must also be watched. It should also be remembered that patients on a low sodium intake who are subjected to withdrawal of serous effusions are in greater danger of developing the low sodium syndrome.

The early enthusiasm for cation exchange resins has waned. They are best reserved for patients unable to accept a low sodium diet, who are sensitive to mercury, as an adjunct when frequent mercurial injections are required, and when all other measures have failed. During the use of resin therapy the water output may decrease so there is no net loss in sodium. The contraindications to resin therapy are essentially the same as for mercurial diuretics. Disturbances in electrolyte balance are not uncommon and acidosis is especially likely to occur.

While rest is an essential feature of the treatment of myocardial failure, absolute bed rest is no longer in fashion, and use of the bedside commode and sitting in a chair is now advocated. While sitting erect may contribute to dependent edema, it impedes blood dilution, increased blood

volume, and increased venous return to the heart which may precipitate dyspnea and pulmonary edema. Bed rest also predisposes to phlebothrombosis and attention should be given to the position of the extremities, and passive motion or gentle active motion of the legs should be encouraged. The wearing of elastic stockings has some merit, but if applied in the presence of considerable edema, dyspnea and cardiac asthma may be produced by the same mechanism as in rest in the supine position. Should phlebothrombosis or intracardiac thrombi give rise to pulmonary embolism the use of anticoagulant therapy is indicated. The frequency of this complication in protracted congestive heart failure has encouraged some to advocate the routine prophylactic use of anti-coagulants. In addition to physical rest one may also induce a decreased metabolic demand by depression of the basal metabolic rate with antithyroid compounds or radioactive iodine. This procedure has replaced total thyroidectomy used to accomplish the same result several years ago. Small doses of thyroid substance may be required to control myxedema. The patient with chronic failure due to idiopathic hypertensive cardiovascular disease may have the work of the heart itself reduced by the use of antihypertensive drugs.

In conclusion, it may be stated that there is no routine treatment for intractable congestive heart failure. The successful management of such a state may tax the most versatile physician to the utmost degree. He must be thoroughly conversant with disorders that precipitate, aggravate, or accompany myocardial failure. It is now more essential than ever before that he make an accurate diagnosis of the heart disease itself. He must understand the normal and pathological physiology of the circulation, and electrolyte and water metabolism. He must be aware of the favorable effects of drugs, their indications and contraindications, and especially their toxic effects. The total patient, not merely his circulatory system, must be considered. In brief, successful therapy demands a most astute medical judgment.

405 Main St.

# Urologic Emergencies

John B. Graham, M.D.  
Chicago

*Acute Obstructive Uropathy.*—Vesical neck obstruction due to prostatic enlargement and allied lesions, is commonly of gradual onset with increasing residual urine. Eventually, many of the patients will have acute urinary retention superimposed on chronic. Exposure with chilling and overindulgences precipitate these episodes. Catheterization is imperative when the distress is severe, and most of these patients can safely have the bladder entirely emptied. However, when a large residual urine of long-standing exists, it is probably safer to decompress the bladder slowly. An apparatus like intravenous tubing and glass Murphy-drip is satisfactory. Many believe that the intravesical and intrarenal pressure decrease is greatest at first, when only a few ounces of urine have been released. Renal vascular "shunts", reflex anuria, and bleeding occasionally occur after sudden emptying.

The Tieman or Coude catheter which has a stiffened and curved tip now can be obtained with a Foley bag. This catheter can be inserted and left inlying when an ordinary straight catheter fails to ride over an elevated bladder neck. Another difficulty may arise in using too large a catheter, or one so small it buckles before the obstruction. Sizes 16 to 20 French are usually optimum. The stylet or mandarin is dangerous in the hands of the inexperienced. Some urinary chemotherapy or antibiotic should be started, since infection usually accompanies instrumentation and stasis in the urinary tract.

After several unsuccessful attempts at catheterizing the patient, it is best to seek specialized assistance. Too much trauma to the urethra may make any catheterization impossible, and an emergency cystostomy may be needed.

*Trauma To The Urinary Tract.*—Extravasation anywhere in the urinary tract necessitates immediate diversion of the urine and drainage of the contaminated tissues. Rupture of the

bulbous urethra can result from kicks and blows to the perineum and straddle or impaling injuries. Chronic inflammatory conditions of the anterior urethra occasionally extravasate, apparently spontaneously or following instrumentation. The urine dissects beneath Scarpa's fascia, and beneath its penile and scrotal equivalents, to levels just below the inguinal ligament and up over the abdominal wall.

Suprapubic cystostomy with incision and drainage of the abdominal, scrotal, penile, and perineal tissues is emergent. Antibiotics have appreciably lowered the mortality. In less desperate instances, the urethral lumen can be re-established through the cystostomy using interlocking sounds, or by doing a perineal urethrotomy. In either case, a catheter is left in over two weeks to splint the urethra. Strictures often occur subsequently.

Fractures of the bony pelvis can tear the urethra in its posterior portion near the bladder. Urine escapes into the perivesical extraperitoneal space. Ruptured bladder also may behave in this way, but many of them are intraperitoneal. Bladder injuries occur most often when the bladder is overdistended. They often accompany falls or automobile accidents. Any difficulty in urinating or hematuria after an accident suggests the diagnosis. The management should be carefully planned. An initial, single, gentle, and aseptic attempt at catheterization can be made. If successful, and the urine is bloody, the patient may have an incomplete tear of the urethra or bladder; the catheter can be left as a splint. Incision and drainage may not be needed. If ruptured bladder is suspected, the practice of irrigating in and out to measure leakage is dangerous. A simple cystogram, using some dilute opaque material, will show the extravasation much more conclusively.

Ruptured kidney accompanies severe blows and penetrating wounds. Some are contusions or shallow lacerations which may cause nausea, pain in the loin, hematuria, and abdominal

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Presented before the Metropolitan Chapter of the American College of Surgeons. The John B. Murphy Memorial Hall, April 19, 1954, Chicago, Ill.

rigidity. If bleeding is not excessive, conservatism with bedrest and careful observation will suffice in three-fourths of the cases. Progression of bleeding with growth of the hematoma on palpation, signs of shock, and increasing hematuria must be treated with replacement of blood and surgery. Excretory or retrograde urography are helpful, but the patient's condition may be too desperate.

*Surgical Trauma To The Urinary Tract.*—Bladder injuries during pelvic surgery, if recognized, can be repaired primarily in one extramucosal layer. Catheter drainage should be employed for about a week. When the trauma goes unrecognized, fistulae are to be expected.

If a ureter is seen to be severed, it can be reapproximated immediately end to end, using fine sutures. A ureteral catheter splint should be left in to intubate the ureter. It can be brought out urethrally with cystoscopic forceps. A crushed ureter, if unclamped, can be splinted postoperatively by retrograde catheterization.

Ureteral injuries, when recognized postoperatively, may allow only incision and drainage of the extravasation because of the postoperative condition and the rising toxemia. A urinary fistula will follow, and often the patient will lose the kidney. Immediate nephrostomy may save the kidney. Deligation of a ureter in the im-

mediate postoperative period is dangerous.

*Hemorrhage.*—Hemorrhage from bladder tumors, enlarged prostates, and post-prostatic surgery are the commonest bleeding problems of emergency proportions. Clots form and obstruct the urethra. Pain and severe urgency to void make the patient urgently seek relief. If a catheter large enough to aspirate out the clots, urine, and blood can be used, relief will be immediate. Bleeding often will stop when the bladder is emptied completely. A hemostatic Foley bag may help control prostatic bleeding.

If catheterization and repeated irrigation with a large piston syringe fail to stop bleeding, suprapubic cystotomy is indicated if urological help is not available. The bladder can be packed or bleeding points coagulated with a bipolar current. The urologist will usually first introduce a 28 Fr. resectoscope which has a rigid sheath and is ideal for aspirating clots. Through this instrument, bleeding points can be coagulated. If this is unsuccessful, he too will resort to cystotomy. Blood replacement is often needed.

#### CONCLUSION

We have attempted to cover highlights in the diagnosis and treatment of commoner urologic emergencies in a short space of allotted time.  
250 E. Superior Street

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## THE GP AND THE PSYCHIATRIC PATIENT

The general practitioner is in an ideal position for necessary environmental manipulation. He may have known the whole family for years and can see relationships and make recommendations that would be impossible for the psychiatrist until he has had repeated contrasts with the family. There are other patients who must be sent to the psychiatrist solely because they will accept his rather obvious commonsense recommendations as coming from a specialist in the field of psychiatry. Certain types of emotional illness will respond to electroshock therapy only.

This is particularly true in the more profound types of depressions with considerable agitation, suicidal drive, or delusion formation. The *George J. Wright, M. D., Psychiatric Aspects Of The Menopause. West Virginia M. J. July 1954.* same holds true for the paranoid type of illness.

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## CORRECTION PLEASE

The article by William J. Corcoran, M.D. of Chicago which appears on Page 326 of our November issue has a typographical error in the title. The correct title is Respiratory Symptom from Sulfathiazole in Agranulocytic Angina.

# Acute Emergencies of the Eye

Ira A. Abrahamson Jr., M.D.  
Cincinnati, Ohio

To discuss all the acute emergencies of the eye would take far more time than allotted this evening.

Sudden loss of vision due to vascular phenomena such as occlusion of the central retinal artery or vein, or optic neuritis due to various causes as well as severe pain in the eye due to acute iritis or glaucoma deserve mention in a paper of this type.

However, I have chosen to discuss four of the most common ocular emergencies which the physician might encounter in daily life and private practice.

## 1. Foreign bodies. (F.B.)

- a. Etiology. They may be one of a large variety: steel, glass, cinder, wood, eye lashes, or the rust ring from a previous F. B. Pictures I and II reveal trichiasis showing how the lashes act as a F. B.
- b. Symptoms. The chief complaints are pain, burning, watering, photophobia, or a scratching sensation on blinking.
- c. Physical exam. It is advisable to take the visual acuity on all cases before treating them to avoid medico-legal problems.

70% of the F. B. are on the palpebral conjunctiva of the upper lid and 25% are corneal, either superficial or deep.

One should be careful in their examination, as history of glass in the eye may be more serious than a corneal abrasion or a F.B.

If no F.B. is seen grossly, the eye should be stained with 2% Fluorescein and a corneal or conjunctival abrasion may appear with a greenish color at the site of the lesion.

- d. Treatment. Install 1½% Pontocaine into the conjunctival sac and remove the F.B. with a cotton applicator if it is superficial, or with an eye spud of the Dix

variety if it is deep. If in doubt, instill an antibiotic drop or ointment, apply a pressure patch to the eye, and refer the patient to an ophthalmologist.

For trichiasis, epilation of the lash will promote immediate relief.

The corneal laceration with the iris prolapse should be patched and referred to an ophthalmologist for immediate surgery. Chloromycetin may be given systemically in these cases as well as T.A.T.

Do not use a cycloplegic such as atropine or Homatropine unless you are positive that no glaucoma exists, or you suspect an iritis to be present.

- e. Complications. The patient should be observed for the development of a dendritic keratitis or a corneal ulcer for which occurrence a more severe medical regime is followed.

## 2. Contusion of the Eye.

- a. Etiology. The most common cause is a blow to the eye by a fist, door, hammer, etc.
- b. Symptoms. Pain in the eye and possible diminution of vision are complained of by the patient.
- c. Physical exam reveals chemosis and ecchymosis of the lids accompanied by a subconjunctival hemorrhage and edema.

The physician should also look for the more serious complications encountered in this condition, such as orbital fractures, ophthalmoplegias, dislocation of the lens, vitreous and retinal hemorrhages, macular edema or hole, retinal detachment, and rupture of the globe.

- d. Treatment. Ice compresses should be applied to the eye for 10 minutes at a time 4 times a day for the first 48 hours, followed by alternating hot and cold compresses for a total of 10 minutes at a time 4 times a day. The administration of an antibiotic drop 4 times a day may

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From the Department of Ophthalmology, Cook County Hospital, Chicago, Ill. Presented before the Metropolitan Chapter of the American College of Surgeons, John B. Murphy Memorial Hall, April 19, 1954, Chicago, Ill.

be advisable if conjunctival infection seems to be present.

Use cycloplegics with extreme caution as they may obscure pupillary findings of a much severer underlying condition.

Bed rest is advised for intraocular hemorrhages and detachments as listed above.

### 3. Chemical Burns.

- a. Etiology. Acid and alkali burns such as brake fluid, amniotic fluid, blood, pus, or lye are common offenders. In Chicago, rumor has it that some bartenders keep a shot glass filled with molasses and lye for customers who become too unruly.
- b. Symptoms. Pain photophobia, burning, redness, and loss of vision are encountered.
- c. Physical exam. The eyes and face are red and the patient has difficulty opening his eyes. Lye burns, like other alkali, are proteolytic and progressive, penetrating deeper with possible later perforation of the cornea.
- d. Treatment.  $\frac{1}{2}\%$  Pontocaine is first instilled, followed by 2% Fluorescein and copious irrigation of the eye for 10 - 15 minutes with water, saline, or whatever is available. One may put the patient's head under a water faucet or into a bucket of water immediately. The time for irrigation is the important factor here.

The dead tissue should be debrided with a cotton applicator. A cycloplegic such as Homatropine or Scopolamine plus an antibiotic ointment may be instilled into the conjunctival sac, fol-

lowed by a pressure patch. These cases should be observed daily for further complications.

4. Laceration of the Lids and Adnexa,
  - a. Etiology. Razor, knife, hatchet, human bite, etc. are the more common causes.
  - b. Symptoms. Pain and bleeding are the chief complaints.
  - c. Physical exam. On physical exam one may find severing of the canaliculus or tear duct apparatus or a through-and-through laceration of the lids.
  - d. Treatment. Lacerations of the canaliculus should be referred immediately to an ophthalmologist for plastic surgery.

The main point to be stressed in suturing lid lacerations is to suture them layer by layer such as conjunctiva, orbicularis oculi, and skin, separately instead of incorporating all 3 layers in one suture.

It is best to suture the conjunctiva and muscle with 3-0 or 4-0 catgut and the skin with 5-0 or 6-0 black silk sutures followed by an antibiotic ointment and patch. T.A.T. should be given and antibiotics may be given systemically.

In closing I should like to stress one important point: if in doubt of your diagnosis, apply a sterile patch to the eye and refer the patient to an ophthalmologist.

### SUMMARY

Although the list of acute emergencies of the eye is numerous, four of the most common conditions have been considered with a brief discussion of their clinical picture and recommended therapy.

808 North Crescent Avenue

## CASE REPORTS



# Transposition of Main Branches of Blood Vessels of Heart with Patent Foramen Ovale

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**Chicago**

Since survival of patients with transposition of the large vessel trunks beyond early childhood is rare, every case deserves detailed analysis from the pathological and clinical viewpoint.

This white male was under clinical observation at the Children's Memorial Hospital from May 1938 (aged 3 years, 1 month) until March 1948 (aged 12 years, 11 months) and at St. Luke's Hospital from October 1948 (aged 13 years, 6 months) until his death on December 2, 1953 (aged 18 years, 8 months.)

At the age of 3 years, he was brought to the clinic, because he could only move in a walking chair, had shown marked cyanosis on crying and was retarded in his physical development. There was marked cyanosis of skin and mucous membranes as well as the clubbing of the phalanges.

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Presented before the Section on Pathology, 114th Annual Meeting, Illinois State Medical Society, Chicago, May 20, 1954.

These signs of anoxia persisted unchanged over the entire observation period of 15 years. Likewise, the compensatory polycythemia persisted between 19 and 22 gm Hb and 7,000,000 and 9,000,000 Erythrocytes /cmm. At the age of 15 years, the resting arterial saturation was 65 per cent, dropped to 27 per cent after very light exercise. (Dr. Donald Cassels at the Univ. of Chicago.) Prior to his death, the correct diagnosis of transposition was suggested, but never established with certainty on account of the following complexing symptoms:

1. Combined fluoroscopy and film studies showed an absence of the pulmonary conus, hence tetralogy appeared more likely. Repeated electrocardiogram revealed left heart preponderance, suggesting tricuspid atresia. The angiogram, performed at the age of 15 years, failed to reveal a pulmonary artery. Since right auricle, right ventricle and aorta filled very promptly, the most probable angiographic diagnosis was Truncus arteriosus communis, with the pul-

monary supply arising from bronchial arteries. The clinical discrepancies found an explanation by the postmortem findings. The aorta was in front and arose from the right ventricle. The pulmonary artery was behind the aorta, on the left side. Just below the aortic ring, the interventricular septum had a deep excavation that did not communicate with the left ventricle. However, the only communication between the ventricles that allowed the crossing of the two circulations was a 2.5 cm. diameter foramen ovale. About 2 cm below the attachment of the pulmonary leaflets in the left ventricle, was an infundibular pulmonic stenosis, with a fibrous ring and surrounding calcified nodules. From the functional viewpoint, it represented the same effect as the infundibular stenosis in tetralogy and was indistinguishable from this more frequent cardiac anomaly in the x-ray film.

Moreover, there were multiple abscesses of the lungs and a chronic osteomyelitis of the right clavicle. A review of the literature shows that even in those cases where two shunts facilitated the crossing of the circulation, e.g. interventricular septal defect associated with patent foramen ovale, the life span of eight to ten years is exceptional.

However, single observations record much longer survival. Messeloff and Weaver described the case of a negress who reached the age of 38 years. She only had a mild cyanosis and not less than three compensatory mechanisms: 1) a large interventricular septal defect. 2) a patent for-

men ovale. 3) two aberrant pulmonary veins that entered the right atrium.

Carns, Richie and Musser described the case of a 44 years old woman with a huge interventricular septal defect and dextroposition of the transposed pulmonary artery. In contrast with these examples, our patient showed a rather unsatisfactory compensation, as far as the size of the shunt is concerned.

Therefore, other factors than the mechanical crossing of the two circulations must be responsible for relatively long survival. Two of these factors must be considered. The first is the gradual adaptation to a tolerable deficiency of oxygen supply.

During the first two years of life, "blue babies" frequently show alarming signs that require hospitalization. If they survive, their physical endurance improves. Such adjustment to anoxia may underlie similar conditions of living as the gradual adaptation of individuals in high altitudes.

The second factor is the retardation of growth and development as a biological defense mechanism. Our 15 years long continuous observation of the weight curve indicates that, with the onset of puberty, there was almost a complete abeyance of progress. In the phase of normally accelerated maturation, the cyanotic organism reacts with a self-preserving cessation of development.

2376 E. 71st St.

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## ALLERGIC DERMATOSES

The beneficial effect of the corticosteroids in allergic dermatoses is transient and there frequently is an exacerbation following their cessation. Many authorities agree that cortisone and ACTH should be used only in the most severe, generalized, nonresponding atopic cases. It must be emphasized that the patient should have the benefit of a complete general examination and X-ray, blood, and urine studies prior

to such therapy. When administering these hormones, care must be taken to maintain a proper chemical balance. The dose must be reduced gradually and never abruptly stopped unless an untoward reaction is seen. It is unwise to administer the corticosteroids to an infected atopic individual unless antibiotics are given concurrently. *A. J. Edelstein, M.D., Tips and Taboos in the Treatment of Allergic Dermatoses. Pennsylvania M. J., June 1954.*

# Jejunal Diverticulosis Complicated by Chronic "Non-Mechanical" Obstruction

**Peter A. Nelson, M.D., F.A.C.S., Robert L. Schmitz, M.D., F.A.C.S. and Eugene M. Narsete, M.D.**  
**Chicago**

Nonmeckelian diverticulosis of the small intestine is not rare. Over 350 cases have been reported. The diverticula may be solitary but are usually multiple, as many as 250 or 350 being present in the same patient<sup>3</sup>. They tend to be localized along one segment of the bowel, usually in the jejunum; but diverticula of other parts of the gastrointestinal tract may be present simultaneously, e.g., in the esophagus, stomach, duodenum, ileum or colon. They are most commonly situated along or within the mesentery but they may arise at any point in the circumference of the gut. They are probably formed by a herniation of mucosa through the defects in the muscularis through which blood vessels travel<sup>4</sup> and hence are false diverticula composed mainly of serosa and muscosa. As a consequence their walls are quite thin and expansile.

As a rule the symptoms associated with jejunal or ileal diverticulosis are vague and not incapacitating and the diagnosis is discovered accidentally by radiography or during celiotomy. The roentgen diagnosis is by no means easy and it has sometimes been difficult to demonstrate the lesions even after their presence has been established incidentally during surgery<sup>3</sup>.

The tendency is to treat this condition conservatively and as a rule it is only when some complication arises, as it does in about 10% of cases<sup>2</sup>, that the patient is subjected to surgery.

Table I

Complications Of, Or Associated With, Non-meckelian Diverticula Of The Jejunum and Ileum

(From Benson, Dixon and Waugh<sup>2</sup> with additions)

## A. Acute mechanical intestinal obstruction

1. From enteroliths formed within diverticula
2. From pressure of inflammatory mass associated with diverticulitis

3. From volvulus of the intestine
4. From stricture or adhesions from ancient diverticulitis
5. From pressure of filled diverticula on intestine

## B. Chronic intestinal obstruction

1. *Without apparent mechanical obstruction*
2. From stricture or adhesions
3. From inversion of diverticulum with intussusception<sup>8</sup>
4. From chronic volvulus<sup>7</sup>

## C. Inflammatory disturbances varying from mild catarrhal inflammation to gangrene resulting in perforation and peritonitis

## D. Intestinal hemorrhage

## E. Rupture of diverticulum

1. Spontaneous
2. Traumatic

## F. Foreign bodies

1. Bones, etc.
2. Parasites
3. Enteroliths

## G. Neoplastic disease and formation of heterotopic tissue

### 1. Benign

- a. Fibroma
- b. Lipoma
- c. Accessory pancreatic tissue

### 2. Malignant

- a. Carcinoma
- b. Sarcoma

## H. Fistula formation<sup>10</sup>

It is the complication of chronic "non-mechanical" obstruction which interests us and which is illustrated by the following cases.

Case 1. Mrs. T.M., a housewife 58 years of age, reported to the Mercy Hospital Free Dispensary on January 20, 1951. For at least 10 years she had had mild recurrent generalized abdominal distress which she related to ingestion of food and which was at least partially relieved by taking baking soda. There was no change in bowel habits. Her appetite was falling

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**Figure 1. The findings at surgery; the dilated and hypertrophied upper jejunum with numerous diverticula lies on the left; the normal lower jejunum lies on the right.**

off and she had lost 12 lbs. over a period of several months.

Physical examination revealed a well preserved, normally nourished white female. Her temperature was 99°, pulse 66, respiration 20 and blood pressure 120/80. There was slight cardiac enlargement to the left and a soft blowing grade 1 systolic murmur could be heard at the apex. The abdomen seemed slightly distended. There were bilateral femoral herniae.

The following laboratory studies were within normal limits: red blood count, white blood count, hemoglobin, differential blood smear, Kahn, urinalysis and electrocardiogram. Chest x-rays, cholecystograms and barium studies of the colon demonstrated only normal organs. Barium studies of the upper gastrointestinal tract demonstrated multiple small bowel diverticula, two of which were in the duodenum, and the rest in the upper jejunum. No evidence of intestinal obstruction was noted.

Conservative management with low-residue diet and intestinal antispasmodics over a period of two months had produced no relief in symptoms and surgical interference was advised.

On January 31, 1951 a transverse incision was made 3 cm. above the umbilicus transecting both rectus muscles. Exploration did not reveal any evidence that the duodenal diverticula were causing any trouble. Beginning just below the ligament of Treitz, the jejunum was dilated to three times normal size and its wall was correspondingly hypertrophied (Figure 1). Nine centimeters below the ligament, the first of 38 diverticula was found; the remainder were scattered along the next 165 cm. of jejunum (Figure 1). The most proximal diverticulum measured 6 cm. in diameter; the size of the remaining diverticula decreased progressively distal ward, the smallest measuring 2 cm. in diam-

eter; the dilatation of the lumen and hypertrophy of the wall of the bowel also decreased progressively distal ward and normal proportions began immediately below the last diverticulum. All diverticula came off at the point of attachment of the mesentery to the bowel and lay within the leaves of the mesentery.

This segment of jejunum was excised and an end-to-end anastomosis accomplished to re-establish intestinal continuity. The duodenum was left undisturbed. Microscopically, the walls of the diverticula were composed of serosa and mucosa only, i.e., false diverticula.

The patient had an uneventful postoperative course and has been free of abdominal complaints since.

Case 2. Sr. C. E., a 37 year old religious, was admitted to Lewis Memorial Maternity Hospital on July 13, 1950. In September of 1949 she had been operated on elsewhere for diverticulitis (location not known) through a lower right rectus incision and a "stone" had been removed from a diverticulum. Following that operation, she had been free of symptoms until her present illness began.

In March 1950 she began having intermittent attacks of diarrhea with considerable generalized abdominal cramping distention. In May, persistent nagging pain appeared beneath the scar of the previous operation and was occasionally accompanied by nausea and vomiting. For one week before admission she had frequent watery stools.

Physical examination revealed a fairly nourished white female. Her temperature was 98.4°, pulse 72, respirations 20 and blood pressure 118/78. General physical examination was negative. There were no abdominal findings except a well healed lower right rectus scar beneath which slight tenderness could be elicited by pressure.

The red blood count, hemoglobin determination, urinalysis, basal metabolic rate and electrocardiogram were normal. The white blood count was 13,400 and the differential smear of the blood revealed 70 polymorphonuclears, 3 eosinophiles, 20 lymphocytes and 7 stab forms. The sedimentation rate was 3 mm./hr. Repeated stool studies were negative for blood, ova, parasites and pathogenic bacteria. Two barium studies of the colon outlined a normal large bowel. Barium studies of the upper gastrointestinal tract demonstrated multiple diverticula of the upper jejunum (Figures 2A and 2B)

Medical management with low residue diet, various intestinal antispasmodics, paregoric, sulfathaladine and chloromycetin was to no avail. The abdominal cramping and the diarrhea persisted. Surgical interference was advised.

On August 11, 1950, the old lower right rectus scar was excised, the rectus muscle split and the peritoneal cavity entered without difficulty. Diffuse, fine adhesions existed between the omentum, small bowel, large bowel and abdominal wall; these were extensively divided. As the upper jejunum was exposed, it was seen to be dilated to at least twice normal size and its wall was correspondingly thickened. Beginning 12 cm. distal to



**Figure 2A.** Upper G.I. x-ray; several diverticula can be seen arising from the jejunum in the lower right hand corner of the picture;



**Figure 2B.** A 5-hour film showing residual barium in multiple diverticula.

the ligament of Treitz was an area of diverticulosis 27 cm. long containing 19 diverticula along its mesenteric border varying from 2 cm. to 2 mm. in diameter. Below the last diverticulum, the bowel was normal in calibre and thickness of wall.

This segment of jejunum was resected and an end-to-end anastomosis was established to reunite the small intestine. Microscopic examination revealed only serosal and mucosal layers in the diverticular walls, i.e., false diverticula.

#### COMMENT

The patient had a smooth recovery, her diarrhea did not return and she has remained well since.

Chronic "non-mechanical" obstruction as a complication of small intestinal diverticulosis has received little recognition. It was described by Benson, Dixon and Waugh<sup>2</sup> in 1943 but since that time there has been only one other specific mention of it in the literature: a case report by Wilkerson and Coffman<sup>9</sup>. However, in cases of diverticulosis reported for other reasons, a careful examination of the pathological or surgical descriptions or of the accompanying photographs will often reveal that abnormal hypertrophy of the bowel wall and/or dilatation of the lumen were also present, although no special significance was attached thereto by the author<sup>1,4,5,6</sup>.

It seems probable therefore that this complication is present to a varying degree in a much greater incidence in small bowel diverticulosis than has been appreciated, especially when the diverticula are multiple. Careful observations should be made at surgery and at autopsy to establish this fact.

The term "non-mechanical" obstruction may be a misnomer in that the entity can be explained on a mechanical basis after all. Normal peristalsis results in the progression of zones of intraluminal pressure along the intestinal tube, strong enough to propel the contents caudad at an effectual rate. If thin-walled, expansile diverticula are present to allow extraluminal dissipation of a part of this pressure there is relative stasis and a proportionately greater effort is required to accomplish the necessary propulsion. Dilatation (from stasis) and muscular hypertrophy (from increased effort) should develop as in any other form of mechanical bowel obstruction.

This explanation can logically be applied to

the few reported cases, with the possible exception of one in Benson, Dixon and Waugh's series<sup>2</sup>. In this case a solitary diverticulum was present in the jejunum, but the associated dilatation and hypertrophy extended just as far distally from the diverticulum as it did proximally. They prefer to consider the bowel changes to be on functional basis and to explain them they postulate a congenital defect of a neurogenic origin concomitant to the diverticulosis. The mechanical explanation which we postulate seems more logical to us.

#### SUMMARY

1. The general features of diverticulosis of the intestine are outlined.
2. The complications of this condition are listed.
3. Two cases of chronic "non-mechanical" obstruction complicating jejunal diverticulosis are presented.
4. It is suggested that this complication may have

a higher incidence than is generally recognized.

5. A mechanical cause for this type of obstruction is postulated.

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## WATERHOUSE FRIDERICHSEN

Acute meningococcemia with shock (Waterhouse-Friderichsen syndrome) is characterized clinically by the sudden onset of headache, high fever, nausea, vomiting, and abdominal pain and with the rapid appearance of petechial and purpuric spots on the skin and mucous membranes with or without meningitic signs. The patient rapidly deteriorates into shock with cyanosis, cold clammy skin, rapid thready pulse, unobtainable blood pressure, and progresses to coma and death within 24 to 48 hours. Before the advent of the sulfonamides, recovery from this syndrome was rare. The combined use of penicillin and sulfonamides increased survival. More recently, the successful use of cortisone and hydrocortisone has been reported. *Norman T. Crane, M.D., et al. Waterhouse-Friderichsen Syndrome. J. M. Soc. New Jersey, June 1954.*

## HELP FOR THE BLIND

Successful blind people, when asked what experience has been most helpful in their rehabilitation, frequently mention a person rather than an event or a mechanical aid. Quite often it is another person who has learned to manage the handicap of blindness. At the right time, for the right patient, a book by a blind person can be helpful. There have been a number of such books, of which Pierre Villey's *World Of The Blind*, translated from the French, remains the classic. *The World At My Fingertips* by Karsten Ohnstad; *Whereas I Was Blind* by Sir Ian Fraser; *My Eyes Have A Cold Nose* by Hector Chevigny; and *The Blind In School And Society* by Thomas Cutsforth all project personalities which may spark the apathetic and paralyzed feelings of the person who has recently learned he must live without sight. *BOOK REVIEW by C. Warren Bledsoe. Am. J. Ophth. Jan. 1954.*

# CASE RECORDS OF THE COOK COUNTY HOSPITAL

KARL MEYER, LEO M. ZIMMERMAN, DEPT. EDITORS

## Cardiac Arrest

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There are very few emergencies that require such prompt treatment as cardiac arrest, for it is the exceptional patient who can survive the anoxia produced by more than three minutes of heart standstill. To re-establish the circulation within this time, the anesthetist and the surgeon must recognize the condition immediately. It is preferable to err on the side of suspicion than to lose time in the case of a true arrest. The surgeon, whether working in the abdomen, chest or elsewhere, should quickly check the lack of pulsations in the great vessels, and then immediately proceed to cardiac massage by the quickest route available. If the abdomen is open, momentary stimulation of the heart may be attempted through diaphragmatic compression, but within seconds the left leaf of the diaphragm should be incised in order to compress the ventricles more effectively. The left chest should be opened through the fourth interspace anteriorly, with severance of the costo-chondral junctions of the fourth and fifth ribs, to facilitate maxi-

mum exposure, in all cases of cardiac arrest unless immediate restoration of heart beat has occurred with the abdominal approach. Since many cases of cardiac arrest occur when neither the chest nor the abdomen is open, a left sided thoracotomy through the fourth interspace anteriorly may be considered the incision of choice. It is of prime importance that oxygen be delivered to the lungs via intra-tracheal tube and that efficient circulation be re-established and maintained by manual massage of the heart. If the resuscitation procedure is not carried out properly, the heart beat may be restored to a patient who has entered a vegetative condition, as brain cells disintegrate in a few minutes with lack of oxygen.

When the heart stops beating, it is either in ventricular asystole or it is in ventricular fibrillation. Ventricular fibrillation in the human heart rarely stops spontaneously and generally shock treatment by means of an electric defibrillator is necessary. The current is turned on for 0.1 or 0.2 seconds (110 volts with 1½ amps.) and the circuit made and broken as the electrodes are applied to the myocardium. A

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jerk and stiffening out of the patient may be expected, as the skeletal muscles also contract. If cessation of fibrillation now occurs, treatment is directed at the cardiac standstill. If fibrillation re-occurs, electric shock must be re-applied. Procaine may be effective in reducing the irritability of the heart, if fibrillation persists. The usual dosage is 5 cc. of a 1% solution given intravenously. Sometimes the above therapy will convert the fibrillating heart to normal rhythm and sometimes to complete standstill. Manual massage will often be sufficient in cardiac standstill, but the heart beat will be strengthened by the injection of adrenalin into the right ventricle. Three to five cc. of 1-1000 adrenalin, diluted with 50 cc. of normal saline, is preferable, though up to 0.5 cc. of the 1-1000 adrenalin without dilution, may be used. If difficulty is encountered in restoring the heart beat, intravenous digitalis may be of some help, and in some cases, calcium gluconate appears to increase the tone of the heart.

There are several methods by which the heart can be squeezed but Johnson and Kirby<sup>29</sup> found that compression of the heart between the thumb in front and the fingers behind produced twice as much blood flow as compressing the heart against the anterior chest wall and five times as much blood flow as compressing the heart from the abdominal side of the diaphragm without incising the latter.

With experience a blood pressure of 80 mm. of mercury or even higher can be obtained. Carotid and radial pulses should be obtainable by the anesthetist during cardiac massage. Whenever possible, the thoracic aorta should be occluded while the heart is being massaged. Wiggers suggested this maneuver as a means of improving the coronary circulation. Johnson and Kirby found that it increased the circulatory output in the carotids. Care should be taken during massage not to rupture or bruise the myocardium. It is comparatively easy to project a finger tip through the softened ventricle wall at this stage. It is also necessary to reduce all pressure on the heart during the stage of filling, so that the heart is free to receive blood. A rate of 60 to 70 per minute is generally adequate.

It is not always necessary to split open the pericardium but as a rule it is done to provide better visibility. When the pericardium in in-

cised, it should be split open widely from its base to apex paralleling the left phrenic nerve, care being taken to avoid the nerve. With restoration of cardiac activity, the pericardium may be left open widely or closed just tight enough to avoid herniation of the heart through the pericardium. During massage the lungs should be well inflated with a respiratory cycle at 18-20 per minute. Lack of proper inflation and deflation of the lungs may be the cause of failure. Should there be any difficulty with intubation, a prompt tracheotomy should be done.

In closing the chest, the internal mammary and intercostal vessels should be inspected for bleeding, and clamped and ligated if necessary. Underwater seal catheter drainage of the thoracic cavity is advisable, after which the incision is closed as in any thoracotomy.

More and more reports are appearing in the literature of cases of acute cardiac arrest followed with complete recovery. To these is added the following case report.

A 67 year old Italian female entered the Cook County Hospital for the third time on April 17th, 1953 with complaints of shortness of breath, swelling of both ankles, and fast heart beat. Her two previous admissions, within the past three years, had been on a similar basis. She had been treated for hypertensive cardio-vascular disease with failure. Present examination disclosed a nodular goiter in a moderately obese white female, in no serious distress. The thyroid gland was enlarged to palpation, BMR was plus 50, and the radioactive iodine uptake was 40% with a higher uptake of radio-active iodine on the right side. Blood pressure was 172/84, pulse 104, respirations 28 and temperature 99 rectally. Admission weight was 139 lbs. The chest was markedly kyphotic with a large anterior-posterior diameter, and there were moist rales scattered throughout both lower lung fields. The heart was enlarged to the left anterior axillary line, but the beat was regular with no murmurs or thrills. The remainder of the examination was essentially negative. Digitoxin therapy was instituted on the medical ward.

On April 20th, 1953 the patient was transferred to female surgery. History here disclosed presence of goiter for 30 years with a 20 pound weight loss in recent weeks. A fine tremor of both hands was observed. The patient was placed

on propylthiouracil 100 mgms qid with white blood counts and BMR's being taken weekly. On June 15th, 1953 Lugol's solution 15 drops tid was begun and the propylthiouracil discontinued. The patient was readied for surgery on June 22nd, 1953 with a hemoglobin of 92%, red count of 4,480,000, white count of 8250 with a normal differential count. The BMR had dropped to a plus 7 on June 8th but then rose again and was a plus 17 the day of surgery. The pulse rate varied from 60 to 88 and the temperature was normal. The patient's weight had risen from 139 to 147 pounds. Pre-operative chest x-ray showed clear lung fields, an enlarged cardiac shadow in the transverse diameter, and angulation of the trachea to the left suggesting a substernal thyroid compatible with the clinical history. ECG showed suggestive coronary insufficiency with auricular fibrillation. The urine was neg.

The patient was brought to surgery June 22, 1953. Anesthesia was begun at 10 A.M. using 20 cc. of 2.5% Sodium Pentothal intravenously, supplemented by ether-oxygen mixture. An endotracheal tube was easily passed, at 10:04 A.M. At 10:08 A.M. the senior anesthetist Dr. Lopez stated that he could no longer feel the radial or carotid pulse. One half minute later the chest was quickly opened through the fourth intercostal space on the left anteriorly without drapes or painting though the operator was gowned and gloved. The heart was motionless on opening the pleural cavity and manual systole was immediately begun at 70 per minute. The thoracic aorta was not compressed, but carotid, radial and femoral pulsations were felt by the anesthetist, indicating satisfactory re-establishment of circulation by cardiac compression. At 10:11 A.M. normal cardiac rhythm and beating were noted with a strong pulse of 60 now obtainable at the right radial area. Oxygen was delivered to the lungs via endotracheal tube and controlled respirations during the above procedure. At 10:15 A.M. closure of the chest was begun using number 32 stainless steel wire throughout. Stainless steel wire was used in anticipation of a wound infection, in the hope that an empyema could be avoided. The pleural cavity was drained with a number 30 catheter through the 8th left intercostal space in the mid-axillary line connected to an underwater seal bottle. On completion of



**Photograph of patient showing healed thoracotomy wound.**

chest closure, the patient's pulse was regular at 60 with a blood pressure of 150/90.

Post-operatively oxygen was started at six liters per minute via intranasal tube. 600,000 units of penicillin and 1 gram of streptomycin were given daily. The patient had not responded orally eight hours post-operatively though her blood pressure and pulse remained entirely normal. She remained bathed in profuse perspiration with a cyanotic tinge to her skin. Secretions were constantly aspirated from her pharynx and trachea with improvement of color. Bronchoscopy was not deemed necessary nor advisable following successful catheter aspiration. Twelve hours post-operatively the blood pressure was 140/90, pulse 86, and respirations 24. The patient was awake and responding to stimulation though somewhat confused mentally. The left chest contained moist rales throughout but the lung was well expanded, with the water seal drain showing only a negligible amount of sero-sanguinous fluid in the bottle. Twenty-four hours post-operatively the patient was remarkably improved and the evening of the 2nd post-operative day oral liquids were well tolerated. At this time, a right facial weakness was noted and the patient appeared confused at intervals. Forty-eight hours post-operatively the patient asked if she might have visitors, and that night she got up and walked into the ward, breaking her water seal drainage apparatus. On June 25th the patient was sitting up eating without dyspnea, and apparently greatly improved. The patient improved daily until June 29th when

her temperature went to 102 rectally and her incision broke down. All skin sutures were removed, the wound irrigated daily with normal saline, and dressed several times daily. Uneventful healing of the wound occurred, thereafter. The patient was discharged on July 18th with no apparent residual facial weakness or mental confusion. She has been followed in the clinic and at present one year post-operatively seems entirely normal both mentally and physically. Her family concur in this.

#### SUMMARY

1. A successfully treated case of cardiac standstill in a 67 year female about to undergo a thyroidectomy is presented.

2. Prompt recognition by the anesthetist and prompt action by the surgeon are necessary for successful therapy, as the time available for restoring circulation without irreversible damage to brain cells is generally considered to be no more than three minutes.

3. Adequate oxygenation of the lungs through an intra-tracheal tube is essential.

4. Proper cardiac massage at a rate of no less than 60 per minute is necessary to maintain adequate circulation.

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# EDITORIALS



## THE OUTSTANDING PRACTITIONER FOR 1955

Henry Orson Munson of Rushville, Illinois, was selected on October 26 by a secret committee as the outstanding general practitioner of Illinois for 1955. Dr. Munson became the Illinois candidate for the national honor, to be determined at the Clinical Session of the American Medical Association in Miami.

Dr. Munson was born near Madrid, New York, August 14, 1867. When he was quite young his family moved to Grinnell, Iowa, where he attended public schools, then he entered Grinnell College for his pre-medical work. He was graduated from the Hahnemann Medical School in Chicago, March 21, 1890 and first located at Warren's Mill, a small logging town in Wisconsin. During the first year between patients, he built a four room house where he took his bride following a Christmas wedding.

In November, 1892, he moved to Astoria, Illinois where he remained nearly three years, then moved to Rushville where he has been in practice continuously almost sixty years. Dr. and Mrs. Munson were the parents of three daughters, Mrs. Munson passing away in 1931. Since that time the doctor has lived with a married daughter. His first post graduate course was taken in London, England, in 1898. He has taken a number of other post graduate

courses in Chicago, Baltimore, and several other medical centers.

In 1901 Dr. Munson attended the Buffalo Exposition, and spent most of his time in the transportation building where automobiles were displayed. Being mechanically inclined, after his return home he began to buy parts, and eventually built his own auto which he used for some little time successfully. Covering a large territory, he delivered approximately 4,000 babies, and he made calls as far as 75 miles from his own home town. On one day he delivered three babies in different counties, and only one of these in a hospital.

He became a member of an adjoining medical society before his own Schuyler County Society was formed. He is still active in society affairs, and has been president of the Schuyler County Medical Society for the past six years. He was a delegate from his home society at the Annual Meeting of the State Medical Society for the 1954 Annual Meeting. Dr. Munson has records of many surgical cases where he operated in the patient's home, in the bedroom, kitchen or dining room, and on many occasions by the light of lamps and lanterns. He states that his own mother was the real incentive for his studying medicine as she was for many years a practical nurse and often had to be a mid-wife when help was not available. Not having

any sons of his own, he formerly stated that he would wait for the next generation. He now has a grandson enrolled in an eastern medical school. During World War I Dr. Munson enlisted and saw service in the Medical Corps in Europe, then returned for service in an American Army Hospital.

In 1940 Dr. Munson was honored at a special meeting of his county society in Rushville when he was made a member of the Illinois State Medical Society Fifty Year Club. The affair was attended by more than 200 physicians and the principal address and the presentation was made by Dr. James H. Hutton of Chicago, then the President of the State Medical Society. He is also a member of the Rushville Rotary Club and has a perfect attendance record over a period of 16 years. He has been superintendent of the local Methodist Church Sunday School since 1917.

Before a modern hospital was erected in his home town, Dr. Munson was a staff member of three hospitals, one 14 miles from Rushville, another 28 miles and the third 60 miles. He frequently had patients in all three hospitals at the same time and did not complain at the distance he travelled in his daily duties. To show that he is still active in practice, only a few days before he was selected as the outstanding practitioner in Illinois for 1955, he was called to see a very sick patient late at night and remained by the bedside of this patient until conditions were much improved before returning home.

He has one patient who is proud to state that Dr. H. O. Munson has been her personal physician for 60 years and has cared for her during many serious illnesses. His first baby delivered in Rushville is now the wife of a prominent Chicago specialist, and he has delivered a third generation in many of his families. He never asked about the ability of the patient to pay for the call or care, and his many friends state that Dr. Munson always accepted every call day or night, even though he knew the bill would never be paid.

Dr. Munson is the seventh Illinois physician to be selected as the outstanding practitioner. In order of their election, those preceding him, are Lee T. Hoyt, Roseville, Andy Hall, Mt. Vernon, Ernest E. Davis, Avon, J. B. Schreiter,



H. O. Munson, M.D.

Savanna, James S. Templeton, Pinckneyville and George A. Dicus of Streator. Of this group, all are living and active except Lee T. Hoyt who passed away in June of this year.

Once more in Illinois, proper tribute has been paid to a deserving physician who has been an outstanding character in his community, and has invariably put service above self in all of his activities.

## WHIPPING BOY

Last month the medical profession was lambasted again, this time by Dorothy Thompson. Her message for the day was, WHY PEOPLE DON'T LIKE THE DOCTORS? and was based on a talk given by Dr. Francis T. Hodges at a meeting of the Oregon State Medical Society.

Miss Thompson's criticism followed the same old patterns: "A doctor treats his patients as though they were feeble-minded. . .the fees of some doctors are geared to what they think the traffic will bear. . .fewer and fewer are willing to visit the patient. . .none sees you as a whole person." A few paragraphs were devoted to fee splitting and surgical rackets.

How can the medical profession be expected to clean its dirty linen if every attempt to do so boomerangs, as in the case of Dr. Hodges's talk. We may be forced to go underground to ac-

compish what more than 95 per cent of our physicians believe is the right thing to do.

The second point is more subtle, yet typical of many writers. Miss Thompson wants it known that what she has said does not apply to her own physician, who is a decent sort of fellow. In this respect, Dorothy Thompson is not so different from the majority of citizens who appear satisfied with the type of medical care they receive. It is the other person who consults those greedy, arrogant, fee splitting doctors mentioned so frequently by enemies of medicine.

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## **ADMISSION TO MEDICAL SCHOOL**

At the 65th annual meeting of the Association of American Medical Colleges, the value of grades and medical aptitude tests was discussed. According to Mr. John M. Stalnaker, the Association's Director of Studies, the premedic's record is one of the best criteria available for acceptance into medical school.

Students who succeed as undergraduates are likely to do the same after entering medical school. In this respect, grades are significant. Exceptions occur: A bright student may become lazy or develop a psychiatric disorder, or a dull student may do unusually well when prodded by the family or inspired by the faculty or his classmates. As a rule, however, medical schools prefer the better student, in much the same way as the more capable practicing physician is preferred by his colleagues when confronted with a serious illness.

The medical aptitude test serves a purpose, as the premedic with good grades often had a high rating, and vice versa. These tests also help in borderline cases. The typical example is the young man who has "always wanted to be a physician" but comes before the admissions committee with many C's and D's because he has neglected to study while in college. The committee is impressed with his plea, "medicine is in my blood" but turns a cold shoulder on the student when it notes the below par aptitude rating for science. Medical schools have learned through experience that the majority of such students are poor risks. They drop out or just get by.

Medical schools known throughout the country for selecting choice students take men and women whose medical aptitude tests are, on an average, 175 points higher than those of less

selective schools. Are these extra brains necessary? Not necessarily, because the smartest and dullest man in each class will contribute to the practice of medicine, provided he graduates. There is a bottom man in every class; he is of greater value to the public than is the student who fails to finish, regardless of his class standing. In other words, it is the finished product that counts.

Mr. Stalnaker states that 87 per cent (6,112) of all students who entered medical schools in 1949-1950 graduated four years later. Eight per cent (595) dropped out for scholastic reasons, illness, or death. Five per cent became irregular students by going into research or teaching. Ultimately, 91 per cent obtained a degree.

The number who dropped out varied from 1 to 25 per cent in different schools. It is here the aptitude test might have proved helpful. Of those who scored under 300 in the scientific section, only 67 per cent graduated on schedule; 94 per cent of those who scored 700 or better were graduated.

The best universities usually attract the best students. Of these, 91 per cent obtained the M.D. degree whereas only 59 per cent of the dull students were graduated, even though they came from the least selective universities.

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## **DR. HAMILTON ELECTED A WORLD MEDICAL ASSOCIATION DIRECTOR**

Dr. Edwin S. Hamilton of Kankakee was elected a member of the 10 man board of directors of the World Medical Association at the recent meeting held in Rome. Dr. Hamilton was one of two physicians representing the United States and the American Medical Association at the meeting, and it was his fifth trip to Europe as a delegate to the World Medical Association.

For a number of years Dr. Hamilton has been Secretary of the A.M.A. Board of Trustees, where he has many important assignments. He made two addresses at the recent meeting held in Rome, and on one of these occasions he opposed some changes in the Code of Ethics of the W.M.A., when he stated that "the doctors of the United States have within their own a Code of Medical Ethics that has proven satisfactory and they are unwilling to accept the new proposals."

In commenting on the recent trip, Dr. Hamilton stated that he could see distinct improvements in the economic condition of the countries outside of the iron curtain each year. He also state that "it is almost impossible to describe our system of medicine to doctors from countries which have had socialized medicine over a long period of time." He also noted that physicians from countries which have had their current system of medical practice over a long period of time feel that their respective systems are working satisfactorily. Those from countries where socialized plans are new, believe that the system can be materially improved.

Many interesting problems of practice in the many countries within the World Medical Association were discussed, and interesting stories were related relative to the economy, living conditions, government and other facets of life. Practically all countries other than Russia and her satellites were represented at the session.

## YOU AND YOUR PUBLIC

Here are some suggestions regarding the business side of medical practice. They are abstracted from publication of the Michigan State Medical Society, entitled "Winning Friends for Medicine".

1. Give recognition and attention to good management of your office and business operations of your practice.
2. Have adequate space and facilities to treat all patients.
3. Employ adequate, qualified personnel and check on their effectiveness and efficiency.
4. Explain medical fees and other medical costs in advance.
5. Never overcharge—never undercut.
6. Reduce or cancel fees when circumstances warrant special consideration.
7. Help save the patient money when possible.
8. Itemize statements.
9. Send bills regularly.
10. Offer long-term plans to patients who have difficulty paying.
11. Promote use of voluntary medical and hospital prepayment plans. Cooperate with patients, insurance companies, and when required, with government agencies in details involved in these relationships.
12. Get adequate information on patient's first visit.

13. Keep public relations principles in mind in following through on collections or when operating through a collection agency.

The following material is abstracted from a publication prepared for the Committee on Medical Economics of the California Medical Association by the Bureau of Medical Economics of the Alameda County Medical Society.

## WHY PATIENTS DON'T PAY

To determine the cause of physician-patient economic difficulties, the Bureau of Medical Economics of the Alameda County Medical Society in cooperation with the California Medical Association conducted a four-month survey covering 1,560 patients whose accounts were delinquent.

Analysis of reasons for non-payment showed the following breakdown:

1. Adjustable Economic Difficulties—19 per cent. These people proved to be undergoing financial hardships when contacted by the bureau. Most involved temporary emergencies.
2. Poor business methods in the doctor's office—30.23 per cent. This included no billing; insufficient information to trace "skips"; statements not itemized; no collection follow-up in the doctor's office.
3. Dissatisfaction with medical services—3.4 per cent. The Bureau found that one-third of this group had justifiable complaint.
4. Responsibility for bill disputed—2.04 per cent. Patients pointed fingers at a divorced husband, a parent, insurance company and others. The Bureau agreed with about a third of them and collected the bill at the proper source.
5. Excessive fee—2 per cent.
6. Patient not informed—21 per cent. This involved the failure of the doctor to make clear financial arrangements with the patient before treatment or rendering the bill. The patient, in some cases, was not informed of laboratory, x-ray and other costs.
7. Negligent: slow pay—9.61 per cent.
8. Personality clashes—.86 per cent. Anger directed at the doctor or his nurse on a personal level.
9. Deadbeats—10.99 per cent.

It is re-emphasized that the above figures represent delinquent accounts only, and do not represent the doctors' total practice.

The Bureau noted that when steps were taken

to correct the above difficulties collections increased as much as 25 per cent and what is more important, patient satisfaction with the physician and with the economics of medicine increased proportionately.

The authors observe that while the patient's expressed reason for non-payment may not be justified by the facts, it still remains his opinion. As such, it is that man's part of public opinion and must be given full credence when considering public relations.

Regarding the itemization of bills the following comment is found in the article:

"When the first knowledge of his debt to the doctor comes with a bill for \$100 or \$500—labeled only 'for professional services' and implying demand for immediate payment—the head of the average middle-class family undergoes perhaps four stages of emotion. First is shock. Next is panic. Then comes anger. And this then could, and does, lead to a search for some reason he shouldn't pay the bill. . . ."

(From The Ohio State Medical Journal)

## THE ADVISORY COMMITTEE TO THE ILLINOIS PUBLIC AID COMMISSION

It has been called to the attention of the Council (Board of Trustees) of the Illinois State Medical Society that the outstanding work and sustained effort on the part of the Advisory Committee to the Illinois Public Aid Commission in behalf of the residents of Illinois and the members of the State Society, has not received sufficient publicity among members of the profession.

Misunderstandings of the functions and duties of this committee, lack of knowledge regarding the committee work in behalf of the profession and the public, all contribute to the feeling of resentment and criticism voiced against the program.

Since all phases of the I.P.A.C. program are governed by law, paid for by appropriations at the state level, plus grants from the federal government, the Advisory Committee can act only in an advisory capacity. It must develop changes in the plan, work toward improvements in every way possible so that good medical care can be given the public. As its second aim, the protection of the members of the profession called upon to work under the provi-

sions governing the program, is always kept in mind.

The program in Illinois has received national recognition; the American Medical Association feels that progress is being made in this state due to the efforts on the part of the medical society and also on the part of the Illinois Public Aid Commission, to work together for the mutual benefit of the people of this state, the members of the profession, and those called upon to head the program.

A letter has been sent to all county medical society secretaries asking that they present to their membership at the next county society meeting, the facts of this situation as it exists, and assure the physicians that their interests and the interests of their patients are being represented to the best of the ability of the chairman and members of his committee, the officers and Councilors of the Illinois State Medical Society.

Any time questions arise, any time criticisms are received, this information should be forwarded to the chairman of the Committee where careful consideration will be given each problem.

An informed profession, aware of the legal aspects of the program, aware of the efforts on the part of the committee, could do much to continue progress and assist in developing needed changes in many existing phases of this work in Illinois.

The Advisory Committee meets six or eight times a year. The sessions start in the afternoon and run through the evening hours. Members of the county society committees are invited to attend to become familiar with the problems encountered by the Committee, and to become cognizant of the amount of time and effort expended.

For your information the Advisory Committee personnel is as follows: Burtis E. Montgomery, Chairman, Harrisburg; Edwin S. Hamilton, 189 S. Schuyler Ave., Kankakee; Julius H. Hess, 104 S. Michigan Ave., Chicago; Harlan English, 139 N. Vermilion St., Danville; Charles P. Blair, 102 South 1st Street, Monmouth; Theodore R. VanDellen, 435 N. Michigan Avenue, Chicago; Joseph W. Compton, 327 Missouri Avenue, East St. Louis; Charles Lesage, 214 First Street, Dixon

Ex-officio: Arkell M. Vaughn, President,

Illinois State Medical Society; Joseph T. O'Neill, Chairman of the Council; Harold M. Camp, Secretary

Sub Committee on Ophthalmology: Watson Gailey, Chairman, Bloomington; Leo P. A. Sweeney, Chicago; Max Hirschfelder, Centralia; Derrick Vail, Chicago

Sub Committee on Radiology: Warren W. Furey, Chairman, Chicago; Fred H. Decker, Peoria; John Gilmore, Chicago; William DeHollander, Springfield

Sub Committee on Dermatology: Harry M. Hedge, Chairman, Evanston; Malcolm Spencer, Danville

**THE ILLINOIS MEDICAL JOURNAL DEADLINE**

Each month the editors receive interesting reports, or announcements of medical meetings to be held somewhere in Illinois. Unfortunately many of these are received after the book is made up for the next issue of the Journal, and it will be too late to publish them in the following issue of the Journal.

We must receive material for this Journal not later than the 12th of the preceding month. Frequently programs for interesting meetings to be held within two weeks of the date they are received, have come to our attention and we can only say that we are sorry they were not submitted before the deadline.

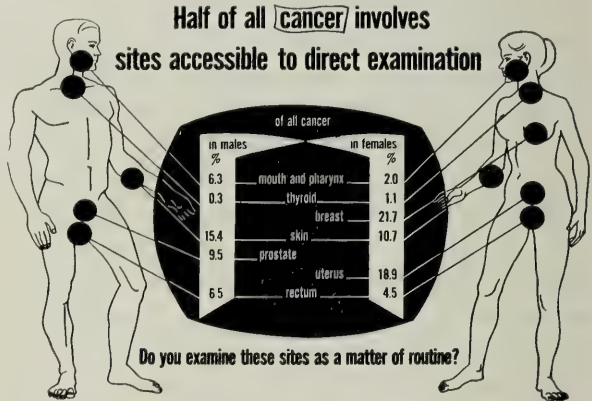
We are anxious to publish information concerning meetings and also data concerning Board examinations, as well as information for News Of The State. However material of this type should reach our office preferably six weeks in advance of the date the Journal is ready for mailing, usually the 15th of the month.

We hope that officers of component and special societies will keep this in mind and mail material so that it will be available before

the 12th of the month, so that it may appear in next month's issue.

**CANCER DETECTION IN THE PHYSICIAN'S OFFICE**

Doctor, by now, you must have heard or read the statement at least once, that a concentrated attack on cancer can only begin when every physician's office becomes a cancer detection center. You may have wondered what po-



tentialities there were in such a program. Based on a recent study of cancer illness among residents of ten large cities in the United States, it would appear that in the age group 45 and over in your practice, 18 out of every 1000 women, and 17 out of every 1000 men will have cancer. The diagnosis of some of these will require the use of facilities not available in the average doctor's office, but at least half of the cases will come under the classification *accessible to direct examination by palpation and diagonal or visualization*. It has been shown by county medical society programs that routine search of these sites for the presence of cancer produces results—the discovery of a substantial number of new cases in the early and curable stage.

# MEDICAL ECONOMICS

**The Medical Economics Committee. John R. Wolff, Chairman, Walter C. Bornemeier, Edward W. Cannady, Roland R. Cross, Jr., E. F. Dietrich, W. W. Fullerton, Edwin F. Hirsch, Frederic T. Jung, W. R. Malony, Caesar Portes, William Requarth, Frederick W. Slobe.**



## December — 1954

**John R. Wolff, M.D.  
Chicago**

As the year draws to a close it is time to contemplate and reflect on the accomplishments and happenings of this past year. It is time to study the forest rather than the trees. And it is time to peer into the future to plan for the new year ahead.

As we of the medical profession look back we see a nation at peace, yet vigilant to the realistic threats of a potential enemy. We see a people who are prosperous, healthy, and filled with the eternal hope of life, liberty, and the pursuit of happiness. As health is our prime concern we look back with contentment and a feeling of a job well done.

And as we look back we see a continued increase in the span of life, a continued lowering of infant deaths, maternal deaths, and deaths due to contagious diseases. We note a continued advance in surgical techniques and methods. Cardiac surgery, aortic grafts and transplants, lung surgery, and the attack on cancer are everyday affairs. Our knowledge of endocrinopathies, our understanding of hepatitis, collagen disorders, and the rheumatoid states are increasing. We are getting closer to the solution of polio and cancer. We know

more about cardiovascular disturbances and we are more aware of the importance of psychosomatic problems. Medical education is proceeding in a smooth steady manner. Today's young physician is truly better equipped to fight disease than ever before. Postgraduate education continues to keep the physician alerted to the new as well as the tried. Hospitals have increased in number and scope. Auxiliary health services have more and more come to the fore to aid us in our everlasting battle against the four horsemen. Research has continued on a great major scale and tremendous strides have been made in every field.

Yes this last year has witnessed the continued advance of American medicine. Our look into the future should be as pleasant as this search of the past years rewards. Yet one cannot help but see certain clouds and a falling barometer that indicates not only stormy weather but actual threats to this progress.

November, 1952 appeared to be a momentous date to everyone interested in the march of health. The repudiation of the socialistic planners by the people of this country and the selection of a political regime entrenched in

the spirit of capitalism gave all of us a great surge of joy. We had the feeling that our March of Health would be continued. Government interference would be stopped. An era of brotherhood between a thoughtful profession and a friendly government seemed to be at hand.

But after much talk, hand shaking, and back slapping we of the medical profession were again attacked. It started with a simple plan called "re-insurance". Before we continue let us examine this great hobbyhour suggestion. Health insurance as such costs money. A premium is paid to the insurance company. The amount of this premium is based upon that expected to be paid out for illness during the year plus a stated amount for administration and a reserve supply. Although the amount paid for illness tends to remain the same throughout the years it may vary greatly from month to month. To offset any possible sudden drain on funds the insurance companies pool part of their reserves together- they insure each other- this is re-insurance. Our present government has offered to aid the insurance companies by doing this re-insurance for them. Money will virtually be given to the companies for this purpose. Describing such a gift as re-insurance is faulty. It is not insurance at all, merely a gift.

When this plan was first presented to congress it was rejected by the insurance companies, the medical profession, and by congress itself.

Yet, in recent political addresses our governmental leaders have not only warned of reintroducing this bill but of also stimulating other legislation concerning health. The exact nature of this new proposal will remain a mystery until its well planned huckster type public relations wise presentation. Why? Why this continued urge for health legislation and this desire for governmental interference?

Cannot our political leaders look back and see the great medical advances of the past century? Can't they see the healthy state of our nation? Can't they see how American medicine leads the world?

Certainly medical care is expensive and insurance costs run high and are not yet all inclusive in their effort to pay the bill. But our strides in the economics of medicine are

also steady and sure. The kinks and shakedown cruises of early insurance experiences are over. We are hovering on a sure ground and at a fast pace. Would that governmental interference was merely talk to stimulate and suggest advances rather than the ever present threat towards control, beaurocracy, and eventual socialization.

Each of us must be alert to these dangers. We must analyze the reason behind each new political or governmental proposal. We must remain as organized as ever in our fight against socialization — especially that of the creeping variety.

But we cannot just sit by and complain. We must present a positive program. And we certainly do have such a program. By continuing the high standards of medical education, fostering research, and practicing our profession in the spirit of Hippocrates we can continue to lead to the health utopia.

The most important part of telling our story remains in our just being good doctors following the life of the beloved physician.

We must take the lead in bringing health insurance to all and in the lowering of the cost of illness. These are two major problems that have many facets and tributaries. Their complexities are well recognized. Our attack on them must be on a scientific basis. We must refrain from emotional and revolutionary procedures. The solutions will be true and far reaching only if we venture forth after sound thinking, careful observation, and precise interpretation of the results.

Progress is always obtained by intelligent thinking and hard work. Research in the economics of medical care must continue to be one of our main themes.

One of the first approaches for each physician is to examine our BLUE SHIELD medical service and its coworker, BLUE CROSS hospital insurance. We must see how we, as individuals, can help lower the cost of this insurance to the patient. Seeing that the unaware stop possible abuses, and doing what we can to provide even more efficient and more rapid recoveries from illness will do much to lower cost. And we must see the need for overall group coverage whereby the entire bill

*(Continued on page 389)*

# CORRESPONDENCE



## CLINICS FOR CRIPPLED CHILDREN LISTED FOR JANUARY

Twenty four clinics for Illinois' physically handicapped children have been scheduled for January by the University of Illinois Division of Services for Crippled Children. The Division will count 20 general clinics providing diagnostic orthopedic, pediatric, speech and hearing examinations along with medical social and nursing services. There will be 3 special clinics for children with rheumatic fever and 1 for cerebral palsied children.

Clinics are held by the Division in cooperation with local medical and health organizations, both public and private. Clinicians are selected among private physicians who are certified Board members. Any private physician may refer to or bring to a convenient clinic and child or children for whom he may want examination or may want to receive consultative services.

The January clinics are:

- January 5—Hinsdale, Hinsdale Sanitarium
- January 6—Alton, Alton Memorial Hospital
- January 6—Clinton, Christian Church
- January 6—Sterling, Field House
- January 7—Chicago Heights, St. James Hospital
- January 11—Peoria, Children's Hospital
- January 11—East St. Louis, St. Mary's Hospital

January 11—Quincy, St. Mary's Hospital  
January 12—Joliet, Will County T.B. Sanitarium

- January 13—Springfield, St. John's Hospital
- January 13—Mt. Vernon, Masonic Temple
- January 13—Elmhurst (Rheumatic Fever), Memorial Hospital of DuPage County
- January 14—Evanston, St. Francis Hospital
- January 18—Danville, Lake View Hospital
- January 18—Peoria, Children's Hospital
- January 18—Salem, Masonic Building
- January 18—Effingham (Rheumatic Fever), Douglas Township Building
- January 19—Evergreen Park, Little Company of Mary Hospital
- January 20—Rockford, St Anthony's Hospital
- January 20—Bloomington, St. Joseph's Hospital
- January 20—Cairo, Public Health Building
- January 21—Chicago Heights (Rheumatic Fever), St. James Hospital

## EASTERN STATES HEALTH EDUCATION CONFERENCE

The 1955 Eastern States Health Education Conference of the New York Academy of Medicine will be held on Thursday and Friday, April 21 and 22, 1955. The Conference will be held at the New York Academy of Medicine, 2 East 103rd Street, New York City. The

Program for the conference will be announced later.

Those desiring additional information should write to Iago Galdston, M. D., Secretary, at the above address.

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### **AMERICAN BOARD OF PHYSICAL MEDICINE AND REHABILITATION**

The next examinations for the American Board of Physical Medicine and Rehabilitation will be held in Philadelphia, June 5 and 6, 1955. The final date for filing applications is March 1, 1955. Applications for eligibility to the examinations should be mailed to the Secretary, Dr. Earl C. Elkins, 30 N. Michigan Ave., Chicago 2, Illinois.

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### **MANUAL ON NURSING SERVICES**

The Public Health Service, of the U. S. Department of Health, Education, and Welfare, announces publication of "How to Study Nursing Activities in a Patient Unit," a manual to aid hospitals in making better use of personnel. The publication offers a method by which hospitals of all sizes may determine how nursing personnel time is distributed between duties requiring nursing skills and those which could be performed by other hospital personnel. The purpose of the study is to give nurses more time to be with patients. Nursing personnel themselves have an opportunity to take part in the study and to analyze their own activities.

Prepared by the Division of Nursing Resources under the direction of Margaret G. Arnstein, R.N., Chief, the manual reflects the Public Health Service's concern with finding ways of making more nursing care available to the public through the conservation and more effective use of scarce nursing skills.

Dr. Edwin L. Crosby, The Director, American Hospital Association, has contributed a foreword in which he says, "If many hours of nurses' time are being directed from their true purpose and spent in work others can do, this trend must be corrected. The problem is how to conserve professional nursing skills for their highest use — and bring the nurse back to the patient. This manual is a practical new tool to use in finding specific answers. . . It gives a scientific method of studying all activities of nursing personnel in a hospital. . . Any hospital, large or small, can use the manual, adapting it readily to individual

needs." The manual may be purchased for 25 cents per copy from the Superintendent of Documents, Government Printing Office, Washington 25, D.C.

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### **AMERICAN BOARD OF OBSTETRICS AND GYNECOLOGY**

The next scheduled examination (Part 1), written examination and review of case histories, for all candidates will be held in various cities of the United States, Canada, and military centers outside the continental United States, on Friday, February 4, 1955.

Case Abstracts numbering 20 are to be sent by the candidate to the Secretary as soon as possible after receiving notification of eligibility to the Part I written examination.

Office of the Secretary — Robert L. Faulkner, M.D. 2105 Adelbert Road, Cleveland 6, Ohio.

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### **YOUR DIRECTORY INFORMATION CARD**

The new, 19th Edition of the *American Medical Directory* is now in galley form, and it is expected that the book will be ready for delivery about the middle of 1955. The previous edition was issued in 1950. Since that time, it has not been possible to publish a new edition because changes in the membership structure of the American Medical Association made it difficult to obtain an accurate list of members.

Within the next few weeks, a directory information card will have been mailed to every physician in the United States, its dependencies, and Canada, requesting information to be used in compiling the new Directory. Physicians receiving an information card should fill it out and return it promptly regardless of whether any change has occurred in any of the points on which information is requested. It is urged that physicians also fill out the right half of the card, which section requests information to be used exclusively for statistical purposes. Even if a physician has sent in similar information recently, he should mail the card promptly to the Directory Department of the American Medical Association to insure an accurate listing of his name and address. There is no charge for publishing the data, nor are physicians obligated in any way.

The Directory is one of the most important contributions of the American Medical Association.

tion to the work of the medical profession in the United States. In it, as in no other published directory, one may find dependable data concerning physicians, hospitals, medical organizations, and activities. It provides full information on medical schools, specialization in the fields of medical practice, memberships in special medical societies, tabulation of medical journals and libraries, and statistics on the distribution of physicians and hospitals in the United States.

### **QUALIFYING EXAMINATIONS FOR FELLOWSHIP IN INTERNATIONAL COLLEGE OF SURGEONS**

Qualifying examinations for Fellowship in the United States Section of the International College of Surgeons will be held on the following dates in 1955: January 31 and February 1; April 25 and 26; July 25 and 26; October 31 and November 1. The examinations will be given at the Cook County Graduate School, and the Cook County Hospital. Applicants are requested to address communications as follows:

Dr. Edward L. Compere, Secretary  
Qualification and Examination Council  
1516 Lake Shore Drive  
Chicago 10, Illinois

### **FELLOWSHIPS FOR THE PRACTICE OF INDUSTRIAL MEDICINE**

The Institute of Industrial Health of the University of Cincinnati will accept applications for a limited number of Fellowships offered to

qualified candidates who wish to pursue a graduate course of instruction in preparation for the practice of Industrial Medicine. Any registered physician, who is a graduate of a Class A medical school and who has completed at least two years of training in a hospital accredited by the American Medical Association may apply for a Fellowship in the Institute of Industrial Health. (Experience in private practice or service in the Armed Forces may be substituted for one year of training.)

The course of instruction consists of a two-year period of intensive training in Industrial Medicine, followed by one year of practical experience under adequate supervision in industry. Candidates who complete satisfactorily the course of study will be awarded the degree of Doctor of Science in Industrial Medicine.

During the first two years, the stipends for the Fellowship vary, in accordance with the marital status of the individual, from \$3000 to \$3,600 in the first year and \$3,400 to \$4,000 in the second year. In the third year the candidate will be compensated for his service by the industry in which he is completing his training.

A one-year course, without stipend, is also offered to qualified applicants.

Requests for additional information should be addressed to the Institute of Industrial Health, College of Medicine, Eden and Bethesda, Cincinnati 19, Ohio.

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### **DECEMBER 1954 (Continued)**

is paid (service benefits) by this insurance.

We must encourage private insurance companies to give better coverage and must aid in exposing those who are not morally sound.

But above all we must not be remiss and fail to tell our great story. Fortunately this is being done. Our press relations and our public relations "know how" is improving. We are not afraid to speak up.

Yes—as we peer into the future we do see the clouds on the horizon, yet we can see that beyond the horizon there are clear skies again. But these clear skies will only be there for us if we bolt down our doors and windows and prepare for the threatening hurricane. Vigilance is the motto of our century. We must continue to remain a well organized group, ready, not only to fight against the inroads of socialism, but to continue in our primary crusade—that of being good doctors.

# NEWS OF THE STATE



## ADAMS

**Society News.**—"Psychiatric Care" was discussed before the Adams County Medical Society at the Lincoln-Douglas Hotel, Quincy, November 8. The speaker was Frank O. Shobe, M.D., St. Louis, instructor in clinical psychiatry, Washington University Medical School.

## COOK

**Owen Wangenstein Gives Ranson Lecture.**—The twenty-fifth Annual Stephen Walter Ranson Lecture, sponsored by Theta Chapter of Phi Beta Pi Fraternity of Northwestern University Medical School, was delivered, November 24, by Dr. Owen H. Wangenstein, head of the department of surgery, University of Minnesota Medical School. His subject was "Peptic Ulcer Problem."

**Changes in Faculty at Chicago Medical School.**—Dr. Leo H. Zimmerman has been appointed chairman of the department of surgery at the Chicago Medical School. A member of the faculty since 1948, Dr. Zimmerman formerly acted as co-chairman. Other changes at the school include the appointment of Dr. Russell M. McQuay, Jr., as an assistant in parasitology, and the following promotions: Waldemar Dasler to associate professor of biochemistry; Aaron Grossman, Winnetka, to associate professor of pediatrics; Lloyd H. Grudset to assistant professor of medicine, and Russell von Milliser, Elmhurst, to professor of pathology.

**Physicians and Wives Guests of Eli Lilly and Company.**—A group of physicians and their wives from Chicago and surrounding areas visited Eli Lilly and Company recently on a two day tour of inspection of pharmaceutical, biological and antibiotic production facilities. Included among the guests were Dr. and Mrs. Donald Nillins, Waukegan; Dr.

Eleanor Hamilton and Dr. Eugene Hamilton, Chicago; Dr. and Mrs. S. J. Karras, Milrose Park; Dr. and Mrs. Harry Paul, Maywood; Dr. and Mrs. W. V. Norak, Milrose Park, and Dr. and Mrs. J. F. Brennan, Chicago; Dr. and Mrs. A. H. Lueders, Hinsdale; Dr. and Mrs. K. L. Duncombe, Downers Grove, and Dr. and Mrs. H. R. Feldotte, Hinsdale.

**University Affiliates With Tumor Institute.**—Affiliation of the Chicago Tumor Institute with the medical and biological research center of the University of Chicago was observed, October 24, with an open house and reception to dedicate the radiation therapy floor in the center which perpetuates the name of the Institute. The reception was preceded by a luncheon at the Quadrangle Club, 57th street and University avenue, at 12:15, for friends and donors to the Institute. At the luncheon, Joseph N. Kallick, president of the Jennie Rubenstein Memorial Association, one of the principal supporting groups of the Institute, presented a check for \$5,000, as the first gift to the University since the affiliation. At the luncheon, brief talks were made by Donald B. Douglas, president of the Institute board, Roy C. Osgood, its treasurer; Dr. Lowell T. Coggeshall, dean of the University's Division of the Biological Sciences, and Chancellor Lawrence A. Kimpton. Dr. Louis L. Mann, rabbi of Chicago Sinai congregation, gave the benediction.

A feature of the affair was the inspection of the extensive battery of radiation devices of the medical center, which comprise the area named for the Chicago Tumor Institute, and other sections in the University's extensive program of cancer research. Among these are the Nathan Goldblatt Memorial Hospital and the Atomic Energy Com-

mission built Argonne Cancer Research Hospital, first specially designed hospital of the nuclear age, which provides many new radiation devices and methods used for research and treatment of cancer. The Chicago Tumor Institute was organized in 1937, largely through the efforts of the late Dr. Ludvig Hektoen, for over 30 years professor and head of the University's department of pathology. He and Dr. Max Cutler, who resigned as director in 1953, operated the Institute as a diagnostic and radiotherapy center. In June of this year the Institute affiliated with the University of Chicago.

**Course for Graduate Physicians.**—A course in Electrocardiographic Interpretation for **graduate physicians** will be given at the Michael Reese Hospital by Louis N. Katz, M. D., (Director of the Cardiovascular Department, Medical Research Institute) and associates. The class will meet each Wednesday from 7:00 to 9:00 pm for twelve weeks, beginning February 2.

Further information and a copy of the lecture schedule may be obtained upon application to Mrs. Anna Rose, Administrative Secretary, Cardiovascular Department, Medical Research Institute, Michael Reese Hospital, Chicago 16, Illinois.

**University News.**—"The Present Status of Poliomyelitis" was discussed by Dr. Harry B. Harding at 7:30 p.m. Friday, November 5, on Northwestern University's Evanston campus.

The lecture, free and open to the public, will be in room 215 of Scott hall, Sheridan rd. and University pl. and is sponsored by Sigma Delta Epsilon, graduate honorary scientific fraternity for women.

Dr. Harding is associate professor of bacteriology in the Northwestern medical school, where he has been a faculty member since 1947. Previously he taught at the University of Arizona and was bacteriologist for the Arizona State Laboratory. He resides at 825 Harms rd., Glenview, Ill.

**New Head of Clinics at Northwestern.**—Dr. Edward S. Petersen, 1322 Astor st., Chicago has been appointed medical director of the Northwestern University medical school's Montgomery Ward clinics, it was announced recently by Dean Richard H. Young.

Dr. Petersen also was named director of the school's graduate division. He will relinquish his post as acting chief of professional services at the Veterans Administration hospital, Chicago.

Retiring director of the Montgomery Ward clinics is Dr. Harley E. Cluxton Jr., who will devote his full time to his private medical practice. Dr. Gordon W. Raleigh, former graduate division director, will give his time to his practice and to his directorship of graduate teaching at Evanston hospital.

An instructor in medicine, Dr. Petersen recently was named medical scholar of the medical school's Women's Faculty club. He joined the Northwestern faculty in 1951, previously having been assistant resident in medicine at the University of Chicago.

Dr. Petersen received his M. D. degree from the Harvard University medical school and served in the U. S. Army medical corps from 1946 to 1948.

**Branch Employs Executive Secretary.**—Miss Dayle Stewart is the new executive secretary of the North Suburban Branch of the Chicago Medical Society. This is a recently created position. The mailing address is the office of Dr. Robert L. Craig, 636 Church Street, Evanston. Dr. Craig is Secretary of the Branch Society.

**Lectures in Psychiatry.**—Fritz Kant, M.D., professor of neuropsychiatry, University of Wisconsin Medical School, Madison, will speak on the "Relationship Between the Physician, the Patient and His Family", January 5. The lecture is the fourth in the Fifth Annual North Shore Health Resort Lecture Series on "Treatment in Psychiatry—II". The lecture will be given at the Resort and all physicians are invited. Edwin F. Gilea, M.D., professor and head of the department of psychiatry, Washington University School of Medicine, St. Louis, gave the third lecture in the series, December 1. His subject was "The Physician's Responsibility to Patients Suffering from Emotional Disorders."

**The Belfield Lecture.**—Lloyd G. Lewis, M.D., professor of urology, Georgetown University School of Medicine, Washington, D.C., delivered the twenty-sixth Annual William T. Belfield Memorial Lecture, October 28, before the Chicago Urological Society, on "Testis Tumors." A clinical program was held in the morning at Cook County Hospital.

## FULTON

**Town Turns Out to Honor Physicians.**—The completion of fifty years in the practice of medicine by Robert T. Ewan, M.D., Lewistown, was observed with public tribute, Sunday, September 26. Designated Dr. R. T. Ewan Day, the ceremonies opened in the morning with a worship hour at the First Presbyterian Church, of which Dr. Ewan had been a life member. In the afternoon a parade led by Dr. Ewan in a horse driven carriage, featured in sequence episodes in Dr. Ewan's life. The Kiwanis Club float showed the physician's first office; the Optimist float, Dr. Ewan as a graduate from medical school in cap and gown in 1904 and modes of transportation used in calling on patients, on foot, on horseback, in a two wheeled cart and with the physician's own old horse-drawn buggy; the I.O.O.F. float showed Dr. Ewan's first office; the Senior Woman's Club float depicted the doctor making his own prescriptions in his office and showed the physician's own horse-drawn sleigh. The D.A.R. Book Club and Home Economics float showed the doctor in the home of a sick patient. This was followed by a float on which rode twelve of the fourteen girls who had worked as secretary for Dr. Ewan in his fifty years of medical practice. The American Legion Auxiliary tableau showed young and old in styles of the "roaring '20's, and the V.F.W. theme

was Flanders Field. This was followed by the Astoria band. Ralph Waughtel, a former driver for Dr. Ewan, drove the physician's old Ford car. The Job's Daughters float showed the great depression of the thirties when a doctor's pay was mostly in groceries and farm produce. The Junior Women depicted a modern delivery room scene at the hospital, with the nervous father in the waiting room. A large number of the babies that Dr. Ewan had brought into the world followed in a group. Then a float on which were seated the Robert Ewan Miller family. Other floats a realistic reproduction of the famous raising of the flag on Iwo Jima by local World War II veterans, and the American Legion's crack color guard. In the parade also were the Havana high school band, a car filled with representatives of Graham Hospital; the 101 Club's tableau of the fallen cross and Sermon on the Mount; Boy Scouts float depicting a "Success for Sale" formula, and the congratulatory float of the Chamber of Commerce.

After the parade a reception was held for Dr. Ewan in the Presbyterian Church parlor.

In the evening, the Rev. Thomas Parkinson opened the program honoring Dr. Ewan in the McNally grade school gymnasium with a special invocation. Willard Fouts then presented Dr. Ewan with the American Legion Citizenship Award for 1954.

The occasion marked the induction of Dr. Ewan into the Fifty Year Club of the Illinois State Medical Society. Dr. Charles P. Blair, Monmouth, Councilor of the Fourth District of the Illinois State Medical Society, presented the insignia, of the Fifty Year Club, a gold pin, and certificate. Other speakers were Drs. F. A. Strauch, president of the Fulton County Medical Society; Everett A. Coleman, Canton; formerly president of the State Medical Society, F. Garm Norbury, Jacksonville, President-Elect of the Illinois State Medical Society; Judge W. S. Jewell, who had known the honored physician since boyhood; Carroll Wickham, general chairman of the program. The Dr. R. T. Ewan Day concluded with a benediction by Rev. David Lehr.

### LAKE

**Society News.**—"The Use of Chlorpromazine in Anesthesia" was discussed by Lieut. D. M. Little, M.C., USNR, before the Lake County Medical Society at the U. S. Naval Hospital, in October. Other speakers were Capt. L. L. Bean, M.C., U. S. Navy, on Coin Lesions of the Chest, and Lieut. A. L. Scherpel, M.C., USNR, Review of Newer Drugs in the Treatment of Hypertension.

### PEORIA

**Symposium on Tuberculosis.**—The Peoria Medical Society was the guest of the Peoria Municipal Tuberculosis Sanatorium, November 16, at a 6:30 dinner. At the scientific session, Dr. Clifton Hall,

deputy director, division of tuberculosis control, Illinois Department of Public Health, discussed "Trends in the Mortality and Morbidity of Tuberculosis"; Otto L. Bettag, director of the Illinois Department of Public Welfare, Direction of Tuberculosis Control, and Karl Pfuetze, medical director and superintendent, Chicago State Tuberculosis Sanatorium, Modern and Future Treatment of Tuberculosis."

### ROCK ISLAND

**Society News.**—At a meeting of the Rock Island County Medical Society at Lutheran Hospital, Moline, Dr. William R. Best, Chicago, spoke on "Current Aspects in the Management of Blood Dyscrasias."

### VERMILION

**Society News.**—Joseph Tarkinton, M.D., neurosurgeon, Evanston Hospital, Evanston, discussed "Aspects of Neurosurgery" at the November 2 meeting of the Vermilion County Medical Society. At a joint meeting of the society with its woman's auxiliary in October, Mr. John Martin of the legislative council of the American Medical Association discussed the bills passed by the Eighty-Third Congress which pertained to medicine.

### WINNEBAGO

**Society News.**—Dr. Erwin R. Schmidt, Madison, Wis., addressed the Winnebago County Medical Society, November 9; his subject was "How the Surgeon and the Anesthetist Can Mutually Help Each Other."

### GENERAL

**Meeting of Chest Physicians and County Society.**—A joint meeting of the Illinois Chapter of the American College of Chest Physicians and the Jefferson-Hamilton County Medical Society was held at the Mount Vernon State Tuberculosis Sanatorium, November 18. Speakers were Drs. Darrell H. Trumpe, Springfield; on "Significance of the Silent Pulmonary Nodule"; D. F. Loewen, Decatur, "Pulmonary Histoplasmosis"; Robert A. DeBord, Peoria, "Management of Chest Injuries", and Abel Froman, Manteno, "Cardio-Respiratory Complications of Esophageal Disease."

**"See Your Doctor" Posters Displayed on Delivery Trucks.**—During December more than 2,500 delivery vehicles of members of the Linen Supply Association of America carried posters urging people to protect their health by seeing their doctor regularly. The colorful 14" x 22" posters read: "Your Doctor Can Keep You Well . . . Have a Check Up Regularly." The posters are being seen by millions of people in nearly every city and town in the United States and Canada.

The poster is part of a year around public relations program which, in association with the Advertising Council, supports worthy civic causes. The program also calls attention to those professions and industries which are most active in main-

taining America's high standards of health and cleanliness, according to a press release.

The Linen Supply Association of America, which has its headquarters at 22 West Monroe Street in Chicago, is the national trade group for 1,042 linen and towel suppliers and allied firms.

**Annual Contest in Proctology.**—The International Academy of Proctology announces its Annual Cash Prize and Certificate of Merit Award Contest for 1954-55. The best unpublished contribution on Proctology or allied subjects will be awarded \$100.00 and a Certificate of Merit. Certificates will be awarded also to physicians whose entries are deemed of unusual merit. This competition is open to all physicians in all countries, whether or not affiliated with the International Academy of Proctology. The winning contribution will be selected by a board of impartial judges, and all decisions are final.

The formal award of the First Prize, and presentation of other Certificates, will be made at the Annual Convention Dinner Dance of the International Academy of Proctology March 26, 1955, at The Plaza Hotel, New York City, New York.

The International Academy of Proctology reserves the exclusive right to publish all contributions in its official publication, "The American Journal of Proctology". All entries are limited to 5,000 words, must be typewritten in English, and submitted in five copies. All entries must be received no later than the first day of February, 1955. Entries should be addressed to the International Academy of Proctology, 147-41 Sanford Avenue, Flushing 55, N. Y.

**Postgraduate Conferences.**—A Postgraduate Conference was held in Cairo, November 17, under the auspices of the Postgraduate Education Committee of the Illinois State Medical Society in cooperation with the faculty of the Stritch School of Medicine of Loyola University and with the Alexander County Medical Society acting as host. In the afternoon, the following physicians spoke: George F. O'Brien, Congestive Heart Failure; Eugene A. Hamilton, Fractures of the Extremities with Reference to Intramedullary Pinning; Arkell M. Vaughn, Indications, Technics and Complications of Gastric Resection; Joseph A. Forbrich, Endocrinology in Children; Robert J. Hawkins, Uterine Hemorrhage with Reference Afibrinogen Anemia, and Harold C. Voris, Management of Closed Head Injuries. In the evening the dinner speaker was John F. Sheehan, dean of Stritch; his topic was "Trends."

On November 18 a conference was held in Lincoln in cooperation with the staff of Augustana Hospital, Chicago, and with the Logan County Medical Society as host. Afternoon speakers were Drs. W. A. Gustafson on Backache: Diagnosis and Treatment, and Lindon Seed, Radioactive Iodine in the Diagnosis and Treatment of Thyroid Diseases. The dinner speaker was George Milles, M.D., pa-

thology at Augustana Hospital, on "Polyps of the Large Bowel: Office Procedure."

**"Your Doctor Speaks."**—Since the last issue of the Illinois Medical Journal, the following physicians have presented transcribed broadcasts in the series "Your Doctor Speaks." The series is presented by the *Educational Committee of the Illinois State Medical Society* in cooperation with *FM Station WFJL*.

**Alfred L. Siegel**, clinical associate in medicine, Chicago Medical School, November 4, Your Heart Attack.

**Edward Bigg**, assistant professor of medicine, Northwestern University Medical School, November 11, on Recent Advances in the Management of Thyroid Disease.

**"All About Baby."**—Since the last issue of the Illinois Medical Journal, the following physicians have appeared on the telecast "All About Baby" over *WBKB, Channel 7*, under the auspices of the *Educational Committee of the Illinois State Medical Society*.

**John L. Reichert**, assistant professor of pediatrics, Northwestern University Medical School, October 27.

**Joseph T. O'Neill**, Ottawa, Councilor Second District, Illinois State Medical Society, November 3.

**Raymond F. Grissom**, member of pediatric staff, West Suburban Hospital, November 10.

**Philip Aries**, attending pediatrician, Mount Sinai Hospital, November 17.

**Lectures Arranged Through the Educational Committee of the Illinois State Medical Society:**

**Marvin A. Rosner**, Chicago, Woman's Council, Max Straus Center, November 23, on What's New in Gynecology.

**Maurice M. Hoeltgen**, Chicago, Senn High School PTA Careers Meeting, November 18, on Medicine and Nursing and Careers.

**Robert R. Dew**, Bloomington, Adult Education Class of the Beason Community High School, November 29, on Understanding the Adolescent.

**Earle E. Wilson**, Oak Park, Von Steuben PTA, December 6, on Mental Health.

**Gilbert H. Marquardt**, Chicago, Health Chairmen of the Illinois Federation of Women's Clubs, January 11, on Recent Advances in Medicine.

**Julius Aronow**, Chicago, Burley PTA, January 18, on Health of the School Child.

**Lawrence Breslow**, Chicago, Horace Mann TPA, January 19, Growing Up with Our Children.

**Lectures Arranged Through the Scientific Service Committee of the Illinois State Medical Society:**

**Manuel G. Spiesman**, Stock Yards Branch of the Chicago Medical Society, December 17, on Pruritus Ani.

**Charles S. Galloway**, Evanston, Whiteside-Lee County Medical Societies in Dixon, January 20, Hemorrhage of Pregnancy.

**Ralph E. Dolkart**, Stock Yards Branch of the Chicago Medical Society, January 21, on Dysentery in Adults: Differential Diagnosis and Treatment.

**J. Keller Mack**, Springfield, Montgomery-Macou-

pin County Medical Societies in Litchfield, February 16, on Baffling Fevers in Children with Particular Reference to Virus Infections.

## DEATHS

C. George Appele\*, Champaign, who graduated at the University of Illinois College of Medicine in 1916, died August 23, aged 70, of carcinoma of the mouth with metastases. He served on the staff of the Carle Memorial Hospital in Urbana and was a past president of the Champaign County Medical Society.

Isadore Edward Bishkow, formerly of Chicago, who graduated at the College of Physicians and Surgeons of Chicago, School of Medicine of the University of Illinois, in 1911, died in Los Angeles, October 12, aged 66. He was formerly associate professor of surgery at the Chicago Medical School.

Zachary A. Blier\*, Chicago, who graduated at Rush Medical College in 1931, died in New York City, November 3, aged 49.

Hugo Branyan\*, Waukegan, who graduated at the Hahnemann Medical College and Hospital, Chicago, in 1909, died October 24, aged 69. He was a member of the staff of the Victory Memorial Hospital.

Clarence Sylvester Bucher\*, Champaign, who graduated at Bennett Medical College, Chicago, in 1915, died August 22, aged 72, of coronary thrombosis. He was a member of the Radiological Society of North America and on the staff of the Burnham City Hospital.

James G. Carr\*, retired, Evanston, who graduated at Northwestern University Medical School in 1902, died October 17, aged 78. He was emeritus professor of medicine at Northwestern and former chief of the medical staff at Evanston Hospital.

Budd C. Corbus\*, retired, Evanston, who graduated at the College of Physicians and Surgeons of Chicago, School of Medicine of the University of Illinois, in 1901, died November 7, aged 78. He had practiced medicine in Evanston and Chicago for 50 years at his retirement in 1951, and was a specialist certified by the American Board of Urology.

George W. Finley\*, Plano, who graduated at Rush Medical College in 1934, died recently, aged 53.

Louis Gereb\*, retired, Maywood, who graduated at Magyar Kiralyi Pázmany Petrus Tudományegyetem Orvosi Fakultasa Budapest, Hungary, in 1917, died September 6, aged 58.

Gustavus Adolphus Goebel\*, Chicago, who graduated at the Chicago College of Medicine and Surgery in 1911, died in Grant Hospital, September 9, aged 91, of arteriosclerotic heart disease.

Frank Coleman Hammitt\*, Peoria, who graduated at St. Louis University School of Medicine in 1919, died October 1, aged 61. He was past president of the medical staff of the Methodist Hospital, and a member of the American College of Chest Physicians.

Ralph W. Kirchner, Chicago, who graduated at Rush Medical College in 1926, died November 5, aged 57, after an illness of two years.

Edwin R. Lescher\*, Elgin, who graduated at Jefferson Medical College of Philadelphia in 1908, died November 9, aged 72.

George Cecil Lewis\*, Danville, who graduated at Rush Medical College in 1923, died September 16, aged 56, of acute myocardial infarction.

Robert J. Lowth\*, Chicago, who graduated at Northwestern University Medical School in 1926, died October 24, aged 60. He was a member of the staff at St. Elizabeth's Hospital.

Hattie B. Melaik\*, formerly of Kewanee, who graduated at Keokuk Medical College, Iowa, in 1897, died in San Francisco, October 10, aged 84.

Carl V. Nyman\*, Rockford, who graduated at George Washington University School of Medicine District of Columbia, in 1903, died October 20.

Olof Olsson, Chicago, who graduated at the College of Physicians and Surgeons of Chicago, School of Medicine of the University of Illinois, in 1905, died October 15, aged 88.

Jennie W. Parks\*, formerly of Cuba, who graduated at the College of Physicians and Surgeons of Chicago, School of Medicine of the University of Illinois, in 1908, died in Glendale, Arizona, recently, aged 80.

Sophie Eliza B. Peattie, Peoria, who graduated at the State University of Iowa College of Homeopathic Medicine in 1890, died September 5, aged 88, of comminuted intertrochanteric fracture of the right femur.

Thomas E. Ryan\*, Ransom, who graduated at Northwestern University Medical School in 1921, died recently, aged 58.

Raymond F. Sheets\*, Carthage, who graduated at Keokuk Medical College, College of Physicians and Surgeons, in 1908, died recently, aged 75.

Walter J. Spencer, Chicago, who graduated at Rush Medical College in 1916, died October 29, aged 64. He was a member of the staff of the Municipal Tuberculosis Sanitarium for the last 20 years.

Edmund Summers\*, Mattoon, who graduated at the Kentucky School of Medicine in 1898, died August 7, aged 82.

George Willard Tucker, Oak Forest, who graduated at the College of Physicians and Surgeons of Chicago, School of Medicine of the University of Illinois, in 1908, died August 13, aged 81, of arteriosclerotic heart disease.

Charles W. Vaughn, Nokomis, who graduated at St. Louis College of Physicians and Surgeons in 1909, died October 27, aged 73.

\* Indicates Member of the Illinois State Medical Society.

# SECTION AND COUNTY SOCIETY OFFICERS

## Illinois State Medical Society

### SECTION OFFICERS, 1954-1955

#### SECTION ON ALLERGY:

Chairman: Max Samter, 1853 West Polk Street, Chicago  
Secretary: Ellis Canterbury, 333 Jefferson Building, Peoria

#### SECTION ON ANESTHESIOLOGY:

Chairman: Ernest F. Kreutzer, 407 Dwight Avenue, Joliet  
Secretary: Arthur T. Shima, 532 North Oak Park Avenue, Oak Park  
Alternate: E. M. Dewhirst, 607 North Logan Avenue, Danville

#### SECTION ON CARDIOVASCULAR DISEASE:

Chairman: V. Thomas Austin, 602 West University Avenue, Urbana  
Secretary: Chauncey C. Maher, 6 North Michigan Avenue, Chicago

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A.M.A. ARCHIVES OF OTOLARYNGOLOGY 59:312 (MARCH) 1954.

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1. Silcox, L.E.: Local Use of Microcrystalline Sulfathiazole in Otolaryngology, A.M.A. Arch. Otolaryng. 59:312 (March) 1954.

\*T.M. Reg. U.S. Pat. Off.

## BOOK REVIEWS



### LECTURES ON GENERAL PATHOLOGY.

Delivered at the Sir William Dunn School of Pathology, University of Oxford. Edited by: Sir Howard Florey, Professor of Pathology. 733 pages; illustrated. \$13.00. W. B. Saunders Company, Philadelphia; London.

This work as the subject states is made up of lectures from a number of people. These lectures are drawn from that course in Oxford, which is termed General Pathology and Bacteriology. Primarily this Oxford course lasts for some two terms of eight weeks each and caters more particularly to the better student.

In the natural flow of events, a book constructed as this one is, the overall consideration brings into the text many ideas not ordinarily presented in the text of a pathology. One aim inherent in these lectures is stimulation of inductive and deductive thinking to exert an influence for research.

These lectures have been edited by Sir Howard Florey, and perhaps from this editing comes a uniform technique of consideration amounting to continuity and smoothness. There is no doubt that each of the contributing lecturers has left in the text evidence of his personality.

Perhaps one of the most valued assets to the reader in his perusal of this volume is the stimulus to think for himself. The study of almost any portion sets up very subtly the "research idea." The perusal of "Lectures on general pathology"

is most certainly not dry reading. The consideration of general principles underlying pathological changes finds good exemplification in this book.

Early in the book there is consideration of The History and scope of Pathology. It is not lengthy, is anything but verbose, and is indeed a pleasure to one, with the least bit of taste for historical consideration.

A portion of the book deals with "Biological Effects of Radiant Energy." A space adequate to this subject for such a treatise is devoted to it. It is indeed dealt with most interestingly. A very technical affair is dealt with most clearly and the reader is not left in a labyrinth of specialism to find his own conclusion. The study of this subject, deals with many facts, not only those changes in tissue that have occurred but also the many factors that have made these changes variable.

For instance in results of atomic energy exposure, the difference made in such by chemical means, by garments, by atmosphere, etc., is dealt with very understandingly. The genetic changes produced by each form of radiant energy is considered in detail. The explanation of why malignant cells are more affected than in those in normal tissue, (where cells are more or less in the "resting stage") is lucid and not stated as facts without at least deductive reasoning.

*(Continued on page 46)*



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**BOOK REVIEWS (Continued)**

A sentence in the conclusion of this radiation subject is quite thought provoking viz: "the change which has made a cell the potential source of a malignat tumor, may not be revealed for many years."

Another subject, very interesting to all physicians is that of "the influence of drugs on inflammatory processes." It is suggested that perhaps more attention will have to be paid in the future to the relationship of the particular antimicrobial drug to the type of lesion on which it is required to act. Today we are all particularly alerted as to the germ on which action is desired.

"In studying drug resistance we serve the practical needs of medicine and encounter, at the same time, some of the basic problems of Biology."

A quite considerable space is devoted to the subject of oedema. This very interesting concept is studied in all its aspects and with reference to the various types of pathology resulting. This portion of the book, in itself would make the work worth while. But this is in no way to be

considered as lessening the actual value of the many other subjects.

Hemorrhage and shock are given adequate discussion. There is not much data that is startling or new, but the manner of consideration is unique and in many instances is stirring to one's imagination.

On the whole this book is quite worth while and is most surely interesting. Not so entirely is this a desertation of morbid anatomy, per se, but the why and how of the morbid anatomy is exemplified and many, many interjections awake the idea of further study in the reader's mind.

C. P. B.

HEART. A Physiologic and Clinical study of Cardio-Vascular Diseases. Aldo Luisada, M.D. Associate Professor of Medicine and Director, Division of Cardiology The Chicago Medical School, Chicago. The Williams and Wilkins Company, Baltimore; Second Edition; 680 pages, 311 figures. Price \$15.00.

Since the first volume of this interesting book was published eight years ago, there have been  
*(Continued on page 48)*

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SUMMIT, N. J.

## BOOK REVIEWS (Continued)

so many advances in the field of cardio-vascular diseases that the author found it necessary to modify, rearrange and rewrite each chapter. Three new chapters appear in this second edition. The author begins with the history of cardiology, the development and structure of the cardio-vascular system, normal function of the heart and vessels. Then in much detail pertinent data concerning the many types of disturbances in these organs and their functions.

He calls attention to the fact that there have been many changes in the evaluation of cardio-vascular diseases with improved methods of management as well as diagnosis, so that the prognosis is rosier than was the case in 1946 when the first volume of the book was published.

A much more hopeful outlook now prevails for the sufferers of cardio-vascular conditions, and many realizing their handicaps find they may remain self-supporting and frequently live out their expectancy. The three new chapters deal first with cardiovascular syphilis in which the au-

thor summarizes data presented elsewhere in the book. The second on the prognosis of cardio-vascular diseases and the third on the social and legal aspects of heart disease in which a number of controversial problems in this field are carefully discussed.

This book, as intended by the author, will be of much value to the student as well as the practitioners in all branches of medicine, as various forms of heart disease play important roles in the progress of many medical and surgical conditions. The reviewer heartily recommends this fine book for the physicians' libraries.

1954 MEDICAL PROGRESS: Morris Fishbein, M.D., Chicago. The Blakiston Company, Inc., New York and Toronto. 345 pages; 1954; Price \$5.00

This book edited by Dr. Fishbein, is a review of Medical Advances during 1953. Twenty-seven contributors produced the material covered in 19 chapters, with the editor giving a summary of the developments of 1953 in the last chapter.

*(Continued on page 50)*

This drug has proved able  
to control the disease  
in two-thirds of patients  
with ulcerative colitis,  
who had previously failed to  
respond to standard colitis  
therapy currently in use\*.



\* See MORRISON: *Rev. of Gastroent.*, Oct. 1953.

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## BOOK REVIEWS (Continued)

Discussed in the book are the major developments in the progress of medicine in the various specialties of medicine during another year. The first chapter, on Cardiology, was written by Dr. Paul D. White of Boston. Among the newer technics used in the detection of heart disease as discussed in much detail, are vector Electrocardiography, angiocardiology and ballistocardiography. He likewise and appropriately discusses the constantly increasing surgical applications in the treatment of congenital heart disturbances, as well as surgical procedures in the relief of valvular defects. Many recent improvements in the diagnosis and treatment of many other conditions, by surgery, medical therapy and general management are likewise discussed in the book on progress for 1954.

The chapter on Newer Drugs, Their Action and Use are also of great interest to the reader. Although it is generally recognized that the infectious diseases nearly conquered, much remains to be done to improve the mortality and morbidity rates of the degenerative diseases.

Recent new applications of *Rauwolfia serpentina* are described, show it to be of value in the management of diseases other than those pertaining to hypertension.

As a ready reference for newer developments in many fields of medical care, this book will be of much value to the medical profession as a whole.

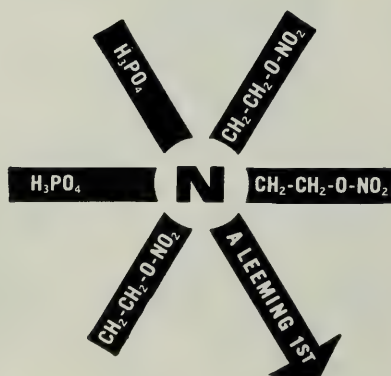
**EMERGENCY TREATMENT AND MANAGEMENT.** Thomas Flint, Jr., M.D. W. B. Saunders Company, Philadelphia-London. 303 pages. 1954. Price \$5.75.

This book is indeed unique in its arrangement, and is intended to aid the physician to determine quickly the proper method of treating emergency conditions. The book is divided into three sections — the first dealing with general medical principles and procedures.

The second section, Emergency Treatment of Specific Conditions, beginning with abdominal pain and listing for many of these conditions, topical references showing where in the book

(Continued on page 52)

# Angina pectoris prevention



The new strategy in angina pectoris is prevention, the new low-dose, long-acting drug—METAMINE. Most effective milligram for milligram, and better tolerated, METAMINE prevents attacks or greatly diminishes their number and severity. *Dosage:* 1 tablet (2 mg.) after each meal; 1-2 tablets at bedtime.

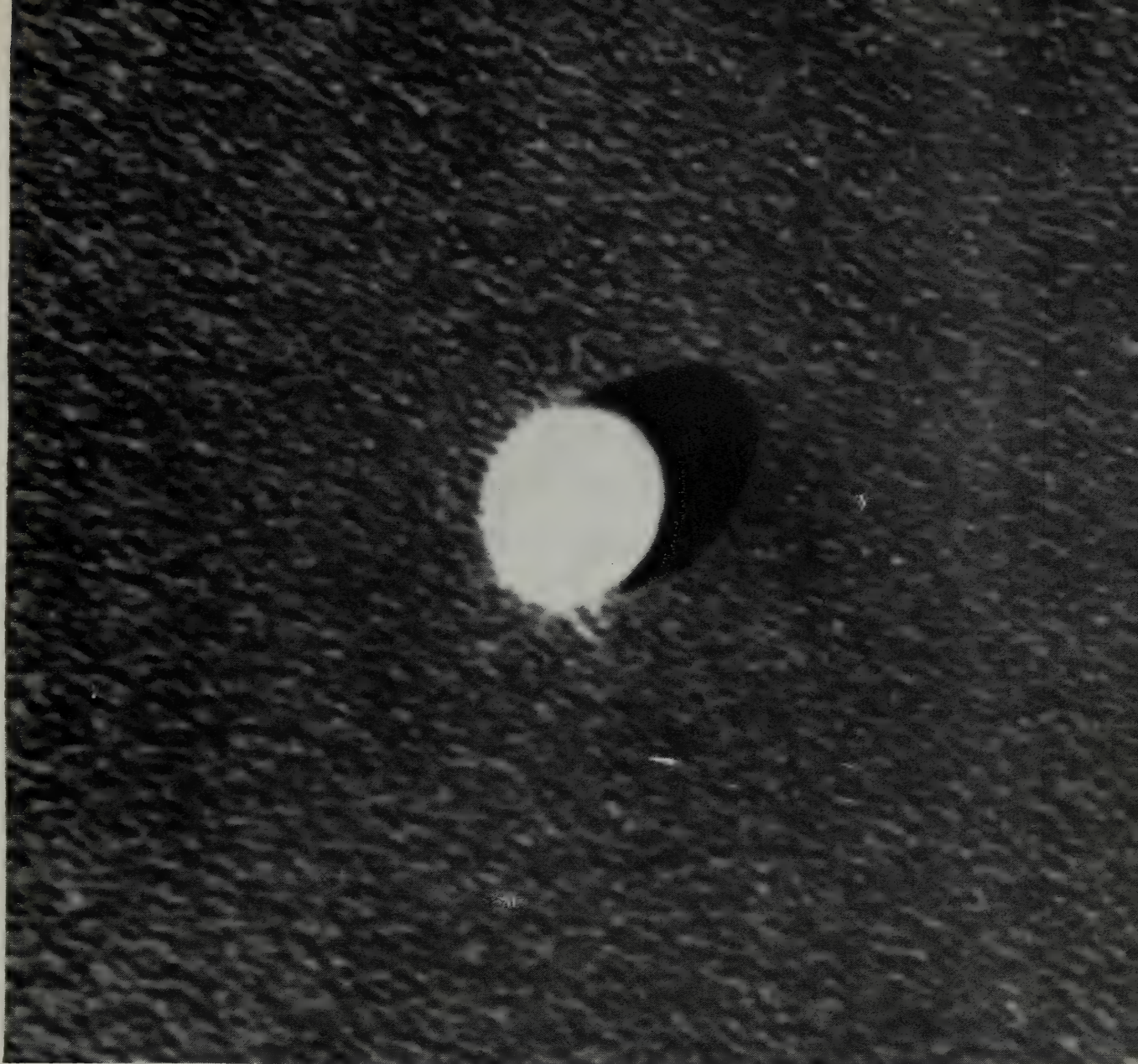
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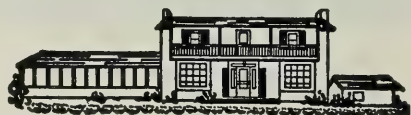
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## BOOK REVIEWS (Continued)

more complete details of management may be found.

The third section entitled Administrative, Clerical and Medicolegal Procedures contains much valuable information for the physician on these procedures. Many questions frequently coming before the busy physician are listed with pertinent information for their solution which are rarely found in a book of this type.

The book is well arranged and will be of interest to physicians in spare moments as a general refresher course on treatment and management of many emergency conditions. The management of acute poisoning, allergic reactions and many other emergency conditions needing quick action for their relief are properly delineated.

This book will be a valuable addition to the library of physicians in general and will be used often as a quick reference work.

## BOOKS RECEIVED

The following books have been received for reviewing, and are herewith acknowledged. This listing should be considered as a sufficient return for the courtesy of the sender. Books that appear to be of unusual interest will be reviewed as space permits each month. Readers desiring additional information relative to books listed, may write the Editor who will gladly furnish same promptly.

**THE SCOURGE OF THE SWASTIKA: A Short History of Nazi War Crimes:** By Lord Russell of Liverpool, C.B.E., M.C., with 16 pages of halftone illustrations. Philosophical Library, New York. Price \$4.50.

**HUGH ROY CULLEN: A Story of American Opportunity;** By Ed Kilman and Theon Wright. Illustrated by Nick Eggenhoffer. Prentice-Hall, Inc., New York. Price \$4.00.

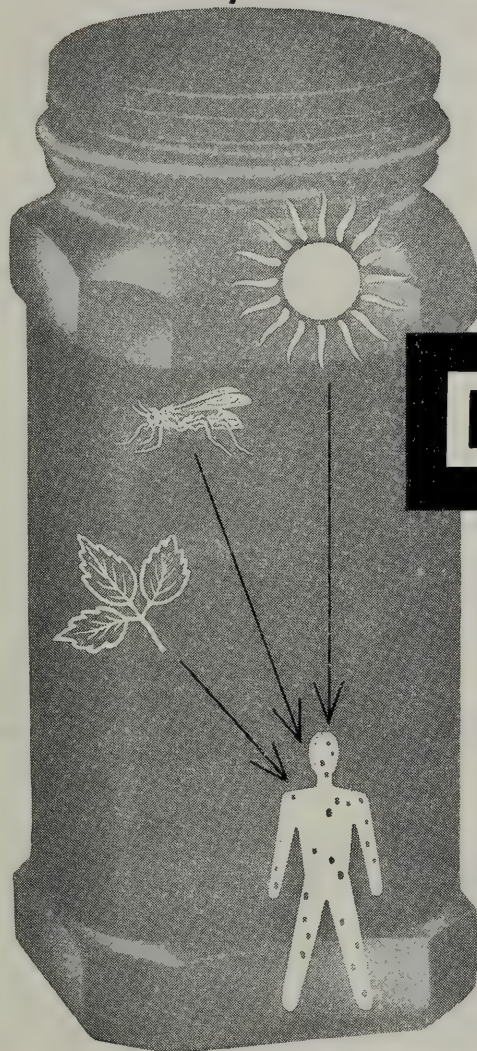
**SMOKING AND CANCER. A Doctor's Report.** By Alton Ochsner, M.D., President American College of Surgeons, 1951, 1952; President, American Cancer Society, 1949, 1950; President, American Association for Thoracic Surgery, 1947-1948. Publishers, Julian Messner, Inc., 8 West 40th St., New York 18. Price \$2.00. Introduction by Evarts A. Graham, M.D.

**UROLOGY: Volumes I, II, and III.** Edited by Meredith Campbell, M.S., M.D., F.A.C.S., Emeritus Professor of Urology, New York University. With the collaboration of fifty-one contributing authorities. Pages: 2,356 thru vols. 1, 2, and 3. Illustrations: 1,148 figures thru vols. 1, 2, and 3. Price: \$60.00 per set. The W. B. Saunders Company, Philadelphia and London.

**PRINCIPLES OF INTERNAL MEDICINE. Second Edition.** Editors: T. R. Harrison, Raymond D. Adams, Paul B. Beeson, William H. Resnik, George W. Thorn, and M. M. Wintrobe. The Blakiston Company, Inc.,

*(Continued on page 54)*

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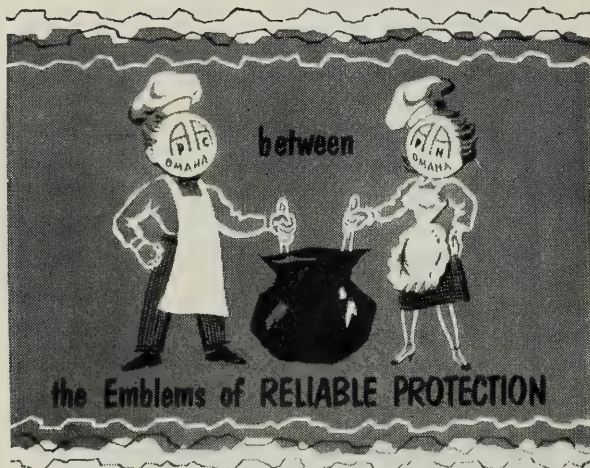
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1. Holland, M. H.: J. Med. Soc. New Jersey 49:469, 1952.

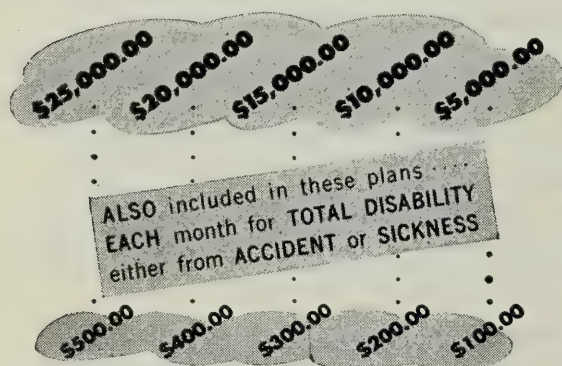
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New York and Toronto. Student 1 Volume Edition, \$16.00; Professional 2 Volume Edition, boxed, \$21.00.

**ANATOMY: Regional and Applied.** By R. J. Last, M.B., B.S., (Adel.), F.R.C.S., Professor of Applied Anatomy, Royal College of Surgeons of England, etc., With 309 Illustrations, many in color. Little, Brown and Company — Boston, 1954. Price \$10.00.

**CURRENT CONCEPTS IN DIGITALIS THERAPY;** By Bernard Lown, M.D., Formerly Assistant in Medicine, Peter Bent Brigham Hospital, and Samuel A. Levine, M.D., Clinical Professor of Medicine, Harvard Medical School; Physician, Peter Bent Brigham Hospital. Little, Brown and Company — Boston. Price \$3.50.

**PROGRESS IN CLINICAL SURGERY:** By Various Authors. Edited by Rodney Smith, M.S., F.R.C.S., Surgeon, St. George's Hospital, London. With 112 Illustrations. Little, Brown and Company — Boston, 1954. Price \$7.50.

**THE MICROPHYSICAL WORLD:** By William Wilson, Ph.D., (Leipzig), D.Sc. (London), F.R.S. Fellow of King's College, London, and Professor Emeritus of Physics in the University of London. Philosophical Library, New York. Price \$3.75.

**THE ANNALS OF THE NEW YORK ACADEMY OF SCIENCES.** Volume 58, Art. 4, Pages 293-540. Editor Roy Waldo Miner. "The Colon: Its Normal and Abnormal Physiology and Therapeutics" Consulting Editor: M. L. Tainter. Price \$4.50.

**THE ANNALS OF THE NEW YORK ACADEMY OF SCIENCES.** Volume 58, Art. 5, Pages 541-720. Editor Roy Waldo Miner. "The Status of Multiple Sclerosis". Consulting Editor: Harold R. Wainerdi. (Conference Chairman, Pearce Bailey). Price \$4.50.

**THE ANNALS OF THE NEW YORK ACADEMY OF SCIENCES.** Volume 58, Art. 6, Pages 721-970. Editor Roy Waldo Miner. "Properties of Surfaces" Consulting Editor, Cecil V. King. Price \$3.50.

**Annals of the New York Academy of Sciences.** Volume 58, Article 2, "Basic Odor Research Correlation," by A. R. Behnke and 33 other specialists. 175 pages, illustrated. Price \$3.50.

**SYMPOSIUM ON PROBLEMS OF GERONTOLOGY.** Nutrition Symposium Series. Number 9. Proceedings of a Symposium held under the auspices of The Johns Hopkins University, School of Hygiene and Public Health and the National Vitamin Foundation, Incorporated, New York City, March 2, 1954. August 1954. \$2.50.

**DISEASES OF THE SKIN.** For Practitioners and Students. By George Clinton Andrews, M. D., F. A. C. P., Clinical Professor of Dermatology, College of Physicians and Surgeons, Columbia University; Attending Dermatologist to the Presbyterian Hospital, Columbia-Presbyterian Medical Center, New York. Fourth Edition. 777 illustrations. W. B. Saunders Company, Philadelphia and London, 1954. \$13.00.

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individualized surgical technic, or a person invention beyond the point of usefulness, and if a word of restraint is offered, pride or stubbornness may dictate a still stronger stand in favor of the pet discovery. *Editorial, Publicity Or Public Interest? Texas J. Med. Dec. 1953.*

Between the two extremes of the finding of a localized indolent process amenable to resection early, and advanced pulmonary tuberculosis requiring several years of rest and antibacterial treatment before surgery can even be contemplated, there is a wide field where judgment is required as to the timing of specific measures. There is no set formula for the application of therapeutic agents, for the reason that in tuberculosis one is dealing not only with a pulmonary disease but also with an individual in whom many factors have to be considered, including the relative prognosis of tuberculosis in different racial groups, the patient's occupation, economic status, home conditions and the various elements which make tuberculosis a socio-economic as well as a clinical problem. Eli H. Rubin, M.D., *Annals of Int. Med.*, March, 1954.

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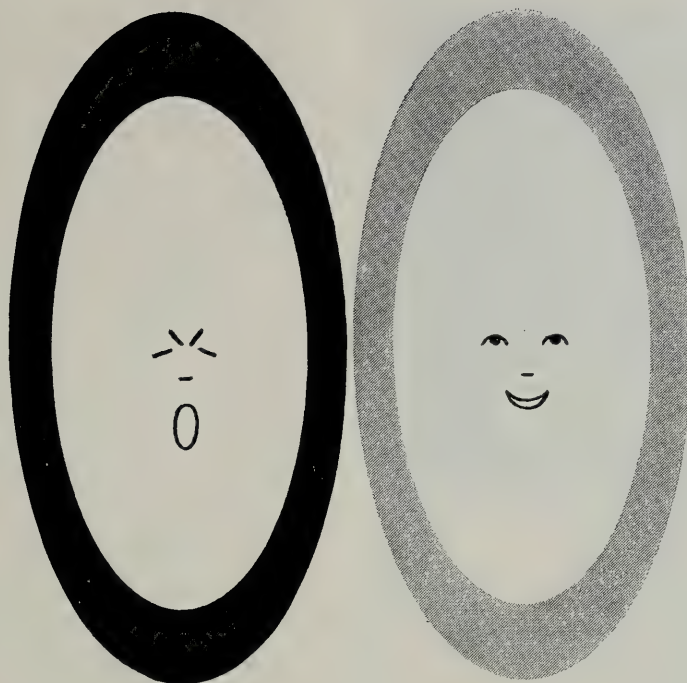
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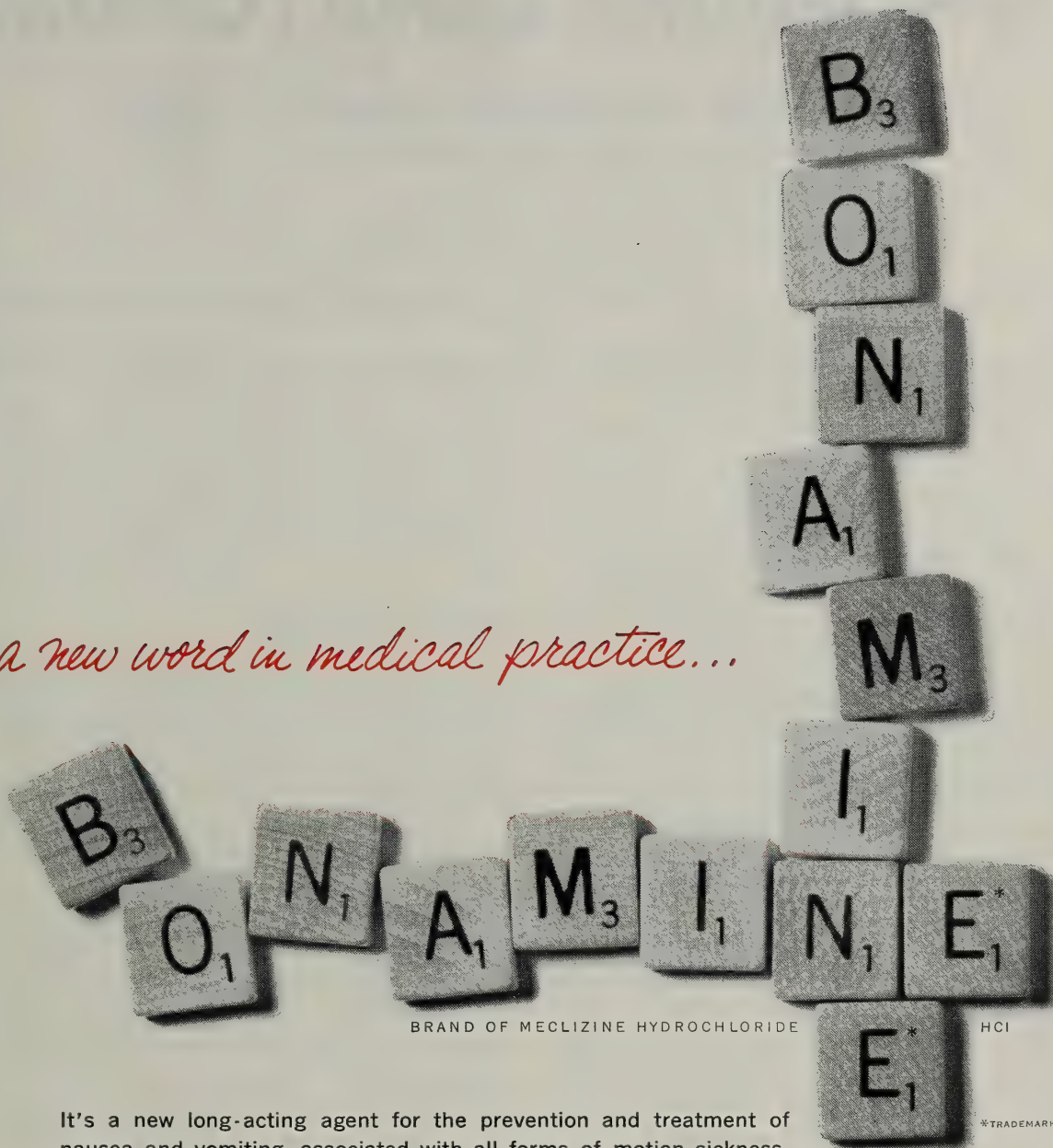
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## PAST HISTORY OF INFANT FEEDING

If the child was to be hand reared, then cow's milk was generally recommended, although not without a discussion of the qualities of other milks. Ass's milk was deemed the most desirable of all the milks from the lower animals, especially for delicate infants. Throughout the 19th century it remained at the top of the list, even though it was almost never obtainable in America. There was one note of dissent—that of the American editor of Hugh Smith's *LETTERS*, who says in a footnote that the story of the efficacy of ass's milk are not well attested. Underwood supported his discussion of the merits of the respective milks by two tables of analysis from the *HISTOIRE ET MEMOIRES DE LA SOCIETE ROYALE DE MEDICINE* of France (1790). Moreover, he recommended the addition of sugar and of thin gruel or barley water as a diluent for milk or, for the older infant, a gelatin mixture could be used in the same way. Others had recommended simple sugar and water dilutions but apart from von Rosenstein, Underwood took the first definite step toward the evolution of a formula. A strong barrier to successful hand feeding was the lack of understanding of the food values of substitutes for breast milk. It has been stated that there was a prejudice against the use of cow's milk for infant feeding during the 18th century, both in England and America. This conclusion does not seem to be warranted. It is true that certain writers on the continent discussed the advisability of omitting all milk and using a pap of bread boiled in beer or wine and diluted with sugar and water, but few agreed with this. *Dorothy L. Jefferson, Child Feeding In The United States In The 19th Century. J. Am. Dietet. A. April 1954.*

A human being is no healthier than his environment. If he lives in an environment in which infection is rife, his chances of avoiding illness are obviously less than those of persons who live where public health and sanitation are good. Frank F. Tallman, M.D., J.A.M.A., May 22, 1954.

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## **PSORIASIS AND METABOLISM**

The contention that infection, neuropathy, diet, vitamin, or endocrine imbalance alone causes psoriasis is insupportable by any pathologic or anatomic evidence. On the contrary, these factors alone or in concert are responsible for acute flares and for chronicity of the disease. If this be so, there must exist some physiologic function adversely affected by them. The most logical answer to this question is "metabolism." Just what exact phase of metabolism is at fault and in what respect is unknown. Carbohydrate, protein, and lipid metabolism have all been indicated by various investigators. The favorable response of the psoriatic to a total starvation regime has been explained facetiously on the basis that the body, in its search for sustenance, is compelled to subsist by metabolizing in some obscure fashion the psoriatic scales. This amelioration during starvation may constitute an expression of the general adaptation syndrome of Selye. Studies show that acute, complete starvation acts as a potent stimulus, causing hypertrophy of the adrenal cortex and

loss of lipids. If only sufficient protein is given, there may be a simultaneous significant increase in adrenocorticotrophin production. *Frank C. Combes, M. D., Management Of Psoriasis As A Metabolic Lipid Disturbance. New York J. Med., July 1954.*

## **WHAT IS AGING?**

We know that death is with us and within us from the first day of life and that on the partial dying of our organism and the regeneration of damaged substance depends the continuation of our life span. Indeed, we are, consciously or not, deeply involved in this violent struggle of defense against the advances of death, and the power of recreation is our most vital weapon. I have on several occasions defined aging as a process in which we do more and more things for the last time and less and less for the first time. This explanation of the dynamic quality of aging offers its most promising therapeutic approach; to try to reverse this movement by doing—in the course of aging—more things for the first time and by trying

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to avoid "Last appearances" in whatever pursuit we follow. Such technic might well be called "recreation" and the best moment for its exercise is when old age begins. *Martin Gumpert, M. D., Geriatrics—A Social Problem, J. M. Soc. New Jersey, Feb. 1954.*

The greatest value to society in these matters is the deterring element. The medical profession ignores this principle, primarily because it tries to be a law unto itself. And, in this capacity, it has failed. *Oliver R. King, Combating Ghost Surgery, New York J. Med. July 1, 1954.*

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Why not kick the scrubs (ghost surgeons) entirely out of the profession? Revoke their licenses. I have asked this question of doctors many times. The answer is, "When we try to do that, they hire a member of your profession (a lawyer) and advance a sob story that they are being deprived of the means of earning a livelihood." In the vernacular, I reply, "So what?" The accused is entitled to counsel and to a fair hearing. The same sob story is advanced by counsel for every lawyer involved in disciplinary proceedings. A disbarment or a suspension deprives the offender of earning a professional living. So does imprisonment. The question is whether or not he is guilty. If so, he should pay the penalty.

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The doctor who leaves his office from time to time to attend the scientific meetings of his state or county medical society is in reality performing a greater service to his patients. A medical practitioner should make every effort to keep abreast of the latest developments in medical science. And patients who find that their doctor has gone to a medical meeting should remember that they will be the principal beneficiaries of his interest in the activities of the medical groups to which he belongs. *Edward J. McCormick, M.D., Firm Ground For Medicine, J. Kentucky M. A. Feb. 1954.*

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## A DRINKING PARTY

The Old Lady of Threadneedle Street can be very old-ladyish. A friend of mine was invited to take part in a symposium in the United States and, although his travelling expenses were being met, he naturally needed a few odd dollars for incidentals. He completed the necessary forms, seeking permission to take some dollars with him and gave as his reason for his trip, "To attend a symposium." He received a strange negative from the Bank of England and, on making inquiries, discovered that the word "symposium" was the stumbling block. "Let's look it up in the dictionary," I suggested resourcefully. The first meaning given was "A drinking party." *Abstracted from The Lancet. West Virginia M. J. July 1954.*

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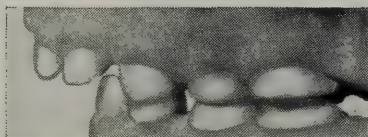
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## TONSILS — IN OR OUT

Since no laboratory test is available to determine whether the tonsils are beneficial or harmful to the patient, the clinician's decision must rest on his own experience, on his evaluation of all the factors, and the prevailing opinion of other recognized observers. The individual examination, based on impressions gathered from experience, is after all the final determinant in a clinical matter in which scientific tests and statistical analyses are not applicable. *Harold E. Harris, M.D., Indications And Contraindications For Tonsilectomy. J. Kentucky M. A. Feb. 1954.*

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diminished reflexes or atrophy or both. However, the results of examination of the central nervous system more frequently are normal. Trigger points may be found. They may be in the occipital region, accompanying the frequent headache of which these patients complain; or they may be over the scapula or the deltoid muscle. *Mark B. Coventry, M.D., Diagnosis Of Shoulder Pain. Wisconsin M. J. May, 1954.*

The value of the routine roentgenographic examination of the chests of all patients admitted to general hospitals has been recognized for almost 30 years, and its advantages over other case-finding methods have been pointed out repeatedly. Yet, until quite recently the major emphasis has been on the mass chest roentgenographic survey, such as those conducted in various cities throughout the country by the Public Health Service in conjunction with the local health organizations. *George Jacobson M. D., and Denis C. Adler, M. D., Am. Rev. Tuberc., June, 1954.*





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**WANTED:** Radiologist, board eligible, experienced. Ill. license, wants ass'n. with hosp., group, or Radiologist. Box 218 Med. JI., 185 N. Wabash, Chicago 1.

## STROKE AND EMOTIONAL STRESS

Ecker has presented 20 cases illustrating the association between cerebral apoplexy and preceding emotional stress. There were 13 cases in which psychiatric studies revealed that the patient had had great difficulty in dealing with aggressive and hostile feelings. There were 15 cases in which a cerebral stroke apparently was precipitated by emotional stress. In eight cases both factors were found. The author proposed that emotional stress provokes cerebral arterial spasm (a change that he has demonstrated in arteriograms). This spasm causes cerebral is-

chemia that in turn contributes to pathologic changes in the brain and its blood supply. He did not imply that emotional stress is the only factor implicated in apoplexy but he expressed the belief that it is an important predisposing factor. He stated, "If this is true, cerebral vascular 'accidents' would not be entirely accidental." *Tips from Other Journals, Emotional Stress Before Apoplexy. GP, June, 1954.*

## LIVE IN THE PRESENT

When one speaks of economic security, it must be remembered that security itself is a relative term. To an intern, an earlier graduate's income of \$10,000 a year generally seems quite large. Yet a physician who earns \$25,000 a year may not feel prosperous; there are too many things competing for slices of his income. Similarly, it is impossible to give all members of one's family perfect financial security either during the physician's lifetime or upon his death. The man who seeks to achieve such an unattainable end by driving himself intolerably hard, becoming a tense and nervous husband and father and breeding ulcers and hypertension in himself or others is unwise. Life is meant to be lived in the present tense, not in retrospect. Yet too few persons realize this fact and may sacrifice what is worth while in life for this financial will-of-the-wisp. *John Alan Appleman, Economic Security for the Physician. New England J. Med. May 13, 1954.*

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